

**CONFIDENTIAL EMPLOYEE HISTORY**

EMPLOYEE NAME <b>Hooper, John W.</b>																										EMPLOYMENT DATE <b>9-25-84</b>						STATUS <input checked="" type="checkbox"/> REGULAR <input type="checkbox"/> PART TIME <input type="checkbox"/> TEMPORARY											
YEARS OF SERVICE 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26																										SECURITY CLEARANCE						LEVEL						DATE GRANTED					

**PAYROLL DATA**

BIRTHDATE <b>9-18-61</b>				SEX <b>M</b>		SOCIAL SECURITY NO. <b>421-90-0925</b>				MARITAL STATUS <b>M</b>				NAME OF SPOUSE <b>Donna</b>				NO. OF CHILDREN <b>-</b>			
FEDERAL WITHHOLDING:				EXEMPTIONS CLAIMED																	
				ADDITIONAL AMOUNT WITHHELD																	

		DATE ELIGIBLE		DATE JOINED		DATE WITHDRAWN		INSURANCE		DATE ELIGIBLE		DATE JOINED		DATE WITHDRAWN	
UNION STATUS		<b>9-25-84</b>						LIFE		<b>9-25-84</b>		<b>9-25-84</b>			
PENSION PLAN		<b>9-25-84</b>		<b>9-25-84</b>				MEDICAL - SELF		<b>9-25-84</b>		<b>9-25-84</b>			
CREDIT UNION		<b>9-25-84</b>						DEP.							
								MAJ. MED. - SELF		<b>9-25-84</b>		<b>9-25-84</b>			
								DEP.							

**GENERAL INFORMATION**

ADDRESS <b>Rt. 1, Box 122</b>				CITY <b>FT. Deposit</b>		STATE <b>AL</b>		ZIP <b>36032</b>		PHONE <b>227-8615</b>	
ADDRESS <b>Rt. 1, Box 27-A</b>				CITY <b>Letohatchee</b>		STATE <b>AL</b>		ZIP <b>36047</b>		PHONE <b>227-4290</b>	
ADDRESS				CITY		STATE		ZIP		PHONE	
ADDRESS				CITY		STATE		ZIP		PHONE	

EMERGENCY NOTIFY <b>Helda McGough</b>				RELATIONSHIP <b>mother-in-law</b>		CITY <b>Same</b>		STATE <b>Same</b>		ZIP <b>Same</b>		PHONE <b>227-8615</b>	
				RELATIONSHIP		CITY		STATE		ZIP		PHONE	

RELATIVES OR FRIENDS EMPLOYED BY THIS CO.		NAMES		RELATIONSHIP		NAMES		RELATIONSHIP	
		<b>Gary McGough</b>		<b>brother-in-law</b>					
		<b>Larry Weldon</b>		<b>"</b>					
		<b>Mike McGough</b>		<b>"</b>					

EDUCATION		ELEM. _____ JHS _____ SHS <b>12th</b>		SPECIAL SKILLS OR TRAINING	
		COLLEGE 1 2 3 4 MAJOR _____			
		OTHER _____			

**TERMINATION RECORD**

<input type="checkbox"/> RESIGNATION	REASON
DATE _____	
<input type="checkbox"/> DISMISSAL	REASON
DATE _____	
<input type="checkbox"/> RECOMMENDED	REASON
DATE _____	

**DEFENDANT'S EXHIBIT****A1**

Form 10

**CITY AND COUNTY OF MONTGOMERY  
PERSONNEL DEPARTMENT  
RECOMMENDATION FOR PERSONNEL ACTION**

Submit in Triplicate

Department/Division Fleet Management - 4800 Date 5/7/04  
 Name of Employee John W. Hooper Effective Date 5/15/04  
 Social Security # 420-90-0925 Classification Auto Mechanic Job Code 5243

Item 2 requires the signature of both department heads. Items 2, 3, 4, 5, 6, 15 require approval of Personnel Director before action is official. Items 3, 4, 5, 7 must have copy of letter to employee attached. Item 8 should have copy of letter of resignation.

- |   |     |   |       |
|---|-----|---|-------|
| 1. Transfer within department .....     | ( ) | 9. Retirement .....                           | ( X ) |
| 2. Transfer to another department ..... | ( ) | 10. Separation by death ..                    | ( )   |
| 3. Demotion .....                       | ( ) | 11. Expiration by Temporary Appointment ..... | ( )   |
| 4. Layoff .....                         | ( ) | 12. Return Leave Without Pay .....            | ( )   |
| 5. Dismissal .....                      | ( ) | 13. Return from Military Leave .....          | ( )   |
| 6. Leave without pay .....              | ( ) | 14. Change of Name .....                      | ( )   |
| 7. Suspension .....                     | ( ) | 15. Change in Salary .....                    | ( )   |
| 8. Resignation .....                    | ( ) | 16. other .....                               | ( )   |

ITEMS AFFECTED BY ACTION	FROM	TO
--------------------------	------	----

Department  
(items 1 & 2)

Classification & Salary  
(items 1 2 3)

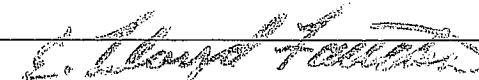
Dates  
(items 6 & 7)

Name  
(Item 14)

Amount  
(Item 15)

Other  
(Item 16)

Funds are available



Disbursing Officer

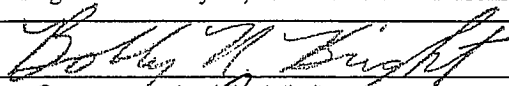
Date

MAY 11 2004

Explanation and remarks (Give reason for any action which is not self-explanatory)

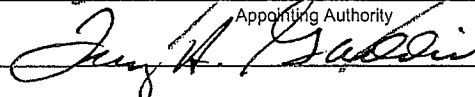
Mr. Hooper will be retiring effective May 15, 2004 for medical reasons.

(Signed) 1.



Date MAY 10 2004

2.



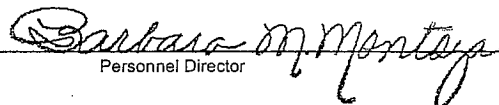
Date

May 7, 2004

3.

Date

4.



Date

MAY 13 2004

FORM 100

## CITY PAYROLL DEPARTMENT

SUBMIT IN TRIPLICATE

## Section A To be completed for items 1, 2, 3, 15 &amp; 16 on Form 10 and Promotion on Form 5

Dept./Div. Number 4800 Employee's Name John W. HooperEffective Date 5/15/2004 Social Security Number: 420-90-0925

MO. DA. YR.

CURRENT CLASSIFICATION & SALARY 5243 s09 11

JOB CODE PAY RANGE STEP

## NEW CLASSIFICATION &amp; SALARY INFORMATION

NEW PAYROLL/DEPT# \_\_\_\_\_

NEW JOB CODE \_\_\_\_\_ NEW PAY RANGE \_\_\_\_\_ NEW STEP \_\_\_\_\_ IF APPLICABLE  
REVIEW DATE FOR  
NEXT INCREASE \_\_\_\_\_  
(MO/DA/YR)

ITEM 15 NEW HOURLY RATE: \_\_\_\_\_ WKLY / BW \_\_\_\_\_ SCH. HOURS \_\_\_\_\_

IF ACTION INVOLVES A PAY OUT ON PAYROLL, WAS EMPLOYEE ADVANCED WORK TIME ON BI-WKLY 4/15/83  
WEEKLY PAYROLL 4/8/83 OR BI-WEEKLY/WEEKLY 1985?no  
YES/NOIF YES: HOW MANY HOURS WERE ADVANCED: (1983) \_\_\_\_\_ HOURS  
(1985) \_\_\_\_\_ HOURS  
TOTAL 0.0 HOURS

AFTER TIME USED ON FINAL TIME SHEET, PAY REMAINING LEAVE BALANCES AS FOLLOWS:

ANNUAL LEAVE HOURS: 1.8  
SICK LEAVE HOURS: 0.6 (1/2 Accrued)  
COMPENSATORY HOURS: 0.0  
PERSONAL LEAVE HOURS: 0.0  
TOTAL LEAVE HOURS: 2.4 LAST DAY IN PAY STATUS: 5/14/2004

## Section B To be completed with Forms 3,5,8,9 &amp; 40 or Re-employment on Form 10

DEPARTMENT/DIVISION NUMBER: \_\_\_\_\_ VERIFIED SOCIAL SECURITY NUMBER \_\_\_\_\_

THE FOLLOWING PERSON HAS BEEN APPOINTED: TEMPORARY: \_\_\_\_\_ PERMANENT: \_\_\_\_\_

NAME: FIRST: \_\_\_\_\_ MI \_\_\_\_\_ LAST \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_  
(MO/DA/YR)

STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

RACE \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ NO. OF DEPENDENTS \_\_\_\_\_ BIRTHDAY \_\_\_\_\_

HOURLY RATE \_\_\_\_\_ JOB CODE \_\_\_\_\_ PAY RANGE \_\_\_\_\_ STEP \_\_\_\_\_ REVIEW DATE \_\_\_\_\_

PAID: WEEKLY \_\_\_\_\_ WILL ACCRUE LEAVE: YES \_\_\_\_\_ WILL PAY RETIREMENT: YES \_\_\_\_\_  
BI-WEEKLY \_\_\_\_\_ NO \_\_\_\_\_ NO \_\_\_\_\_

SCHEDULED HOURS PER PAY PERIOD: \_\_\_\_\_ NON-SCHEDULED, PAID HOURS WORKED ONLY: \_\_\_\_\_

WAS EMPLOYEE PREVIOUSLY EMPLOYED BY THE CITY OF MONTGOMERY? \_\_\_\_\_ PAID WKLY OR BW \_\_\_\_\_  
YES/NOIF YES: DEPT # \_\_\_\_\_ TERM. DATE \_\_\_\_\_ PREVIOUS SERVICE  
MONTHS DAYS YEARS

REMARKS:




# City of Montgomery, Alabama

## Employees' Retirement System

### MEMORANDUM

TO: TERRY H GADDIS, DIRECTOR  
FLEET MANAGEMENT DEPT

FROM: CLAIRE KING   
ADMINISTRATOR

DATE: 04/16/04

SUBJECT: EMPLOYEE RETIREMENT

This is to inform you JOHN W HOOPER, has filed the necessary application with the Employees' Retirement System for their retirement to be effective 05/16/04. The last day for active status (work time, leave time or off days) will be 05/15/04.

4/16/04

To → Clare  
King.  
Retirement  
andTerry  
Gaddis

April 15, 2004

JDD

Mayor:

Attached is a disability retirement request of employee John Hooper. He is unable to work regularly at the garage, and I recommend his case be referred to the Retirement Board for possible disability retirement.

Attachment

JDD

JDD

/rld

I spoke with Traci in the Retirement Office 4/19/04 and she says the next retirement board is scheduled to meet 12 May but she will schedule him to meet with our City Atty. Highly prior to the Retirement Board Mtg.

JDD

## MEMORANDUM

**TO:** Retirement Board  
City of Montgomery

**THRU:** Mayor Bobby Bright  
Mayor City of Montgomery

**THRU:** Mr. Jeff Downes  
Executive Assistant to the Mayor

**FROM:** Mr. Terry H. Gaddis, Director  
Fleet Management Department *18*

**DATE:** 15 April 2004

**SUBJECT:** Recommendation for Medical Retirement for  
Mr. John W. Hooper, SSAN: 421-90-0925

*4/16/04  
approved to  
forward to  
R.B.  
APR*

I recommend consideration of a Medical Retirement for Mr. John W. Hooper.

I have attached a copy of a medical statement from his personal physician, A. Stuart Hendon, M.D. to substantiate this recommendation.

Mr. Hooper has exhausted all of his benefits under the Family Medical Leave Act as well as his annual, sick and compensatory leave with the City. He is constantly complaining that he is sick which prevents him from performing his assigned daily duties.

Mr. Hooper presently has 19 years and 6 months with the City of Montgomery.

THB/bw

1 Atch

Dr. A. Stuart Hendon's medical statement, dated 14 April 2004.

**Montgomery Family Medicine, P. C.**

Brian W. Elrod, M.D.  
Eric W. Graves, M. D.  
Jeffrey W. Mathis, M.D.  
A. Stuart Hendon, M.D.  
Daniel L. Moore, M.D.  
P.O. Box 240369  
8190 Seaton Place  
Montgomery, Alabama 36124  
Phone: (334) 396-9100  
Fax: (334) 396-9110  
www.MontgomeryFamMed.com

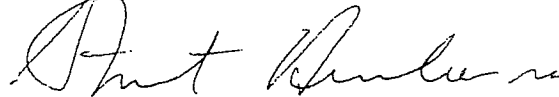
April 14, 2004

Dear Sir,

I have been the primary physician for John Hooper since February, 2003. I have noticed a rapid decline in Mr. Hooper's health since that time. His degenerative hip disease has rapidly progressed to the point he is physically unable to perform his job. His gastrointestinal problem, persistent nausea, has persisted despite aggressive therapy. His anxiety has calmed somewhat.

I understand Mr. Hooper plans to retire in 6 months. However, I feel an earlier retirement for medical medication would be appropriate. Currently his medical condition does not allow for full duty and it is my fear his incapacitation will only worsen and persist.

Sincerely,



A. Stuart Hendon, M.D.  
ASH/asp





## City of Montgomery, Alabama

BOBBY N. BRIGHT  
Mayor

MONTGOMERY CITY COUNCIL  
MRS. ALICE D. REYNOLDS-Pres.  
JAMES A. NUCKLES-Pres. Pro tem  
WILLIE COOK  
TERANCE D. DAWSON  
CHARLES W. JINRIGHT

TRACY LARKIN  
B. J. (BEN) MCNEILL  
P. E. (PEP) PILGREEN  
CHARLES W. SMITH

### CERTIFIED MAIL

John Hooper  
3555 US Highway 31  
Latachaatchee, AL 36047

April 8, 2004

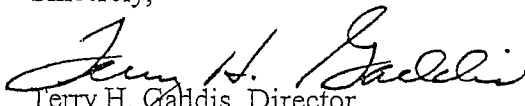
Dear John:

This letter is to serve as an official notification that your final date to be excused from duty under the provisions of the Family Medical Leave Act will be April 12, 2004. Since you have exhausted all of your accumulated leave and authorized 12 weeks leave provided under the Family Medical Leave Act, you must return to full duty status on April 13, 2004. If you fail to return to full duty status on April 13, 2004, I will have no choice but to initiate procedures for termination of your employment with the Fleet Management Department and the City of Montgomery.

While I am concerned about you, I must also be concerned about the hardship your continued absence is causing the other employees in your work center. It is essential that you attend work in order for the Fleet Management Department to maintain production requirements and accomplish our daily mission.

It is my sincere hope that you will be able to return to work on April 13, 2004. As always, I am available to talk with you about your employment status.

Sincerely,

  
Terry H. Gaddis, Director  
Fleet Management

THG/lb



(Please Print Clearly)

B. Date of Delivery

Hooper

4-9-04

7000 0520 0016 1203 1331

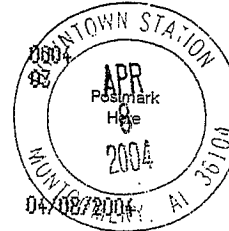
LETOHATCHEE AL 36047

Postage \$ 0.37

Certified Fee \$2.30

Return Receipt Fee  
(Endorsement Required) \$1.75Restricted Delivery Fee  
(Endorsement Required) \$0.00

Total Postage &amp; Fees \$ \$4.42



Recipient's Name (Please Print Clearly) (To be completed by mailer)

John Hooper

Street, Apt. No.; or PO Box No.

3555 Hwy 31

City, State, ZIP+4

Latochoatchee AL 36047

PS Form 3811, July 1999

See Reverse for Instructions

PS Form 3811, July 1999

Domestic Return Receipt

102595-00-M-0952

Mail ☐ Express MailMail ☐ Return Receipt for MerchandiseMail ☐ C.O.D.

Delivery? (Extra Fee)

☐ Yes

6 1203 6331

Montgomery Family Medicine, P. C.

Brian W. Elrod, M.D.  
Eric W. Graves, M. D.  
Jeffrey W. Mathis, M.D.  
A. Stuart Hendon, M.D.  
Daniel L. Moore, M.D.  
P.O. Box 240369  
8190 Seaton Place  
Montgomery, Alabama 36124  
Phone: (334) 396-9100  
Fax: (334) 396-9110  
www.MontgomeryFamMed.com

18  
2/19/04  
Knox K  
Albright AS  
cy: Mr. Hooper's  
Personnel File

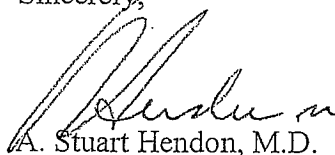
February 17, 2004

Dear Sir,

John Hooper has been treated in my office for severe panic attacks, abdominal pain, and chest pain since October 01, 2003. These symptoms intensified despite aggressive medical treatment. He is now improved with current medications. It is impossible to estimate the duration of his condition. He, at times, is unable to work at his position because of his medical problems.

It is medically necessary at times for him to be off work or excused from work. I can not estimate a duration of time this may occur. He is to return to my office in mid to late March for re-evaluation.

Sincerely,



A. Stuart Hendon, M.D.

ASH/asp



CITY SHOPS DEPARTMENT

CITY OF MONTGOMERY

W R I T T E N   R E P R I M A N D

TO: Mr. John W. Hooper #397

FROM: Terry H. Gaddis, Director  
City Shops Department

SUBJECT: Written Letter of Reprimand

DATE: 30 December 1997


Mr. John W. Hooper, Employee Number 397, is being given a Written Reprimand for clocking out Badge Number 395 on the afternoon of 26 December 1997.

Operating Instruction No. 08 Paragraph 2 states that each individual is responsible for punching the time clock and it is not permissible for any person to clock in or out with a time card other than his own.

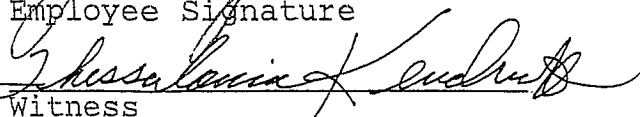
When Mr. Hooper was leaving at the end of his shift on Friday, 26 December 1997, he clocked out using the badge of another employee.

You are hereby reminded that receiving three (3) reprimands in a 180-day period for any violations in Paragraph 8 will result in a three-day suspension without pay. This is your first reprimand in this 180-day period. This 180-day period will end 24 June 1998.

THIS LETTER OF REPRIMAND HAS BEEN READ TO MR. HOOPER.

  
Terry H. Gaddis, Director

  
Employee Signature

  
Witness

BADGE: 393  
 GROUP: 0630-1500-02  
 EMP : WILKES, D

DATE	CLOCK IN	CLOCK OUT	ROUND IN	ROUND OUT	REG	OT1	OT2	OT3	ST1	ST2
PERIOD TOTALS					0:00	0:00	0:00	0:00	0:00	0:00

BADGE: 395  
 GROUP: 0700-1530-99  
 EMP : MOSELEY, K

*clocked by Hooper*

DATE	CLOCK IN	CLOCK OUT	ROUND IN	ROUND OUT	REG	OT1	OT2	OT3	ST1	ST2
12/26/97	15:25		15:25	15:25M	0:00	0:00	0:00	0:00	0:00	0:00
PERIOD TOTALS					0:00	0:00	0:00	0:00	0:00	0:00

BADGE: 397  
 GROUP: 0630-1500-99  
 EMP : HOOPER, J

DATE	CLOCK IN	CLOCK OUT	ROUND IN	ROUND OUT	REG	OT1	OT2	OT3	ST1	ST2
12/26/97	6:53	15:25	6:53	15:25	8:32	0:00	0:00	0:00	0:00	0:00
PERIOD TOTALS					8:32	0:00	0:00	0:00	0:00	0:00

BADGE: 398  
 GROUP: 1300-1530  
 EMP : GRACE, K

DATE	CLOCK IN	CLOCK OUT	ROUND IN	ROUND OUT	REG	OT1	OT2	OT3	ST1	ST2
12/26/97	6:53	15:25	6:53	15:25	8:32	0:00	0:00	0:00	0:00	0:00

## M E M O R A N D U M

TO: Mr. John W. Hooper #397  
Automotive Mechanic

FROM: Mr. Terry H. Gaddis, Director  
City Shops Department

DATE: 4 April 1996

SUBJECT: Letter of Counseling On Excessive Absenteeism

Although I am totally aware and compassionate of your time off due to the medical attention and required recovery time for your workmen's compensation injury, I am very concerned about your called-in absences starting the day you were released by the doctor to return to work. Your unscheduled absences have caused undue hardship not only in the production effort of your work center, but to your fellow employees and supervisor as well. The motorcycle shop has had a tremendous daily workload and your supervisor has had to use personnel from other work centers to assist the motorcycle shop to "just keep up"! When we have to utilize personnel from other work centers, the entire production effort of the Department suffers.

As you are aware, this is not the first time I have counseled you on your unacceptable attendance and your need to build up your annual and sick leave balances. You were given previous letters of counseling on 28 February 1995 and 28 September 1995. Again, you have exhausted your leave balances, and received two and one half (2 1/2) hours time off without pay for your absence on 2 April 1996.

As I have counseled you before, we need you here to work every day. I am going to allow you the two and one (2 1/2) hours off without pay for 2 April 1996, however this final letter of counseling is hereby notice to you that if you should call in your absence and you have no annual leave or a valid written doctor's excuse for any illness, I will have no choice but to suspend you without pay for three to five days, as explained in your counseling letter of 28 February 1995. If this trend continues after any suspension, I will recommend your dismissal of employment from this Department to the mayor.

I strongly urge you to make every attempt to immediately correct this situation.

Acknowledge Receipt by:

*John W. Hooper*  
-----  
John W. Hooper #397  
Automotive Mechanic

*Shirley K. Kendrick*  
Witness

*4-4-96 J.W.H.*  
Date

## M E M O R A N D U M

TO: John Hooper

FROM: Terry H. Gaddis, Director  
City Shops Department

THRU: Eugene Knox, Jr., Asst Director  
City Shops Department

DATE: 28 September 1995

SUBJECT: Letter of Counseling

This record will confirm the counseling session held on 28 September 1995.

Since January 1995, you have called in to notify the Department that you would be late to work or absent from work a total of 32 times. You have also been absent from work for various reasons a total of 34 times. 1 were scheduled and 33 were unscheduled for a total of 262.5 hours.

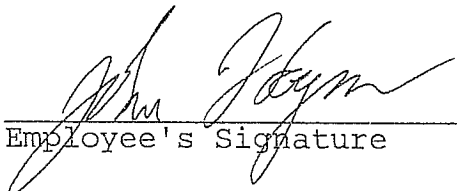
You were made aware that your absenteeism is considered to be excessive as compared to the general population of other employees in this Department and is affecting the capability of your Division to accomplish its daily mission. When you are absent, unscheduled, someone else has to perform your duties and many times, work has to be delayed and rescheduled. This has a negative impact on our production effort and causes unnecessary hardships on your supervisor, co-workers and the Department.

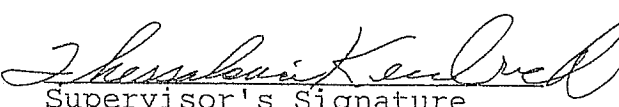
We have been very lenient and understanding of your past absenteeisms and you know that if a true emergency arises, we will grant your request for leave. You are also aware that we encourage you to take scheduled time off from work to relax and enjoy whatever you like to do and we realize that from time to time you require time off for medical/dental appointments. All of this is part of the benefits you have earned and all we ask is that you don't abuse your benefits.

You are reminded that you have a big responsibility to be present for work, on time, everyday, unless there is a true emergency.

This Department prides itself on accomplishing an enormous amount of quality work with a limited number of personnel, but we cannot continue to make this happen without you being present for work.


I strongly suggest that you take immediate action to correct your absenteeism and be a more dependable employee. Your job is important not only to you, but us and we need you present for work!

  
\_\_\_\_\_  
Employee's Signature

  
\_\_\_\_\_  
Supervisor's Signature

M E M O R A N D U M

TO: Mr. John W. Hooper #397  
Automotive Mechanic

FROM: Mr. Terry H. Gaddis, Director   
City Shops Department

DATE: 28 February 1995

SUBJECT: Letter of Counseling On Excessive Absenteeism

I realize that you have experienced several unfortunate, personal misfortunes and medical problems which have prevented your reporting to work; however, you need to understand that your work section has suffered in production output due to your absenteeism.

During the past eight months, you have been absent 43 full-days (344 hours) and have taken off a total of 27.5 hours during various other days. One hundred five point nine (105.9) of the 344 hours were charged as Leave Without Pay. When compared to the absenteeism of other department employees, I consider your absenteeism excessive.

Because you have used all of your vacation time, sick leave, personal leave days, and compensatory time, I have tried to be understanding and compassionate of your personal needs and have allowed you to take time off without pay.

During previous verbal counseling sessions, and on numerous occasions, you have told me that you were going to try your best to be present for work and build-up your annual and sick leave balances; however, you continue to call-in sick or ask for time off. The end result is that we depend on you and need you here to work - doing your part to ensure our production goals are met. When you are absent, we have to pull an employee from another section to perform your duties. This situation creates a negative impact on our production effort and a hardship on the entire shop.

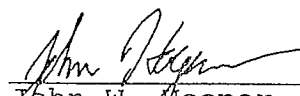
This letter is formal notification that I will not approve any future leave without pay. I strongly advise that you make some kind of arrangements to take care of your needs, whether personal or medical, and ensure you are: (1) Present for work, and (2) Build-up your annual and sick leave.



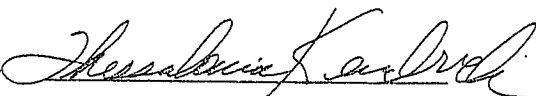
If you continue to be absent from work without earned leave, you will give me no choice but to suspend you for three (3) to five (5) days without pay.

A copy of this Letter of Counseling will be placed in your Official Personnel Folder.

I have this date received a copy of this Letter of Counseling on Excessive Absenteeism:

  
John W. Hooper #397  
Automotive Mechanic

DATE: 2-28-95

WITNESS: 

DATE: 2-28-95

M E M O R A N D U M

TO: Mr. John W. Hooper

FROM: Mr. Donald R. Hayes, Director  
City Shops Department

DATE: 03 January 1992

SUBJECT: Written Reprimand

1. Mr. John W. Hooper is being given a Written Reprimand for failing to produce a physician's certificate to substantiate his illness on 31 December 1991.
2. Mrs. John W. Hooper called stating that Mr. Hooper was sick on 31 December 1991. She was instructed by the Production Controller, Mr. Raymond D. Ewbank to have Mr. John W. Hooper bring in a physician's certificate for his illness on 02 January 1992. You failed to do so.
3. Should you fail to bring in a physician's certificate in the future, I will recommend suspension or dismissal.

This Reprimand has been read to Mr. Hooper.

Robert F. Wade  
WITNESS

John Hooper  
EMPLOYEE SIGNATURE

Donald R. Hayes  
DONALD R. HAYES, DIRECTOR

M E M O R A N D U M

To: John W. Hooper  
Memorandum-for-Record

From: Eugene Knox, Jr. *EK*  
Assistant Director, City Shops

Date: 03 October 1991

Subject: Absenteeism

This will confirm the verbal counsel session held in my office on 03 October 1991.

You were made aware that your absentee record was above average for the period between 10-01-90 through 09-30-91.

During this period, you were absent from duty a total of thirty-three (33) separate occasions, 8 were scheduled and 25 were unscheduled. A total of 228.6 hours. You stated to me that you would take corrective action to change this pattern.

cc: Personnel File

CITY OF MONTGOMERY

W R I T T E N R E P R I M A N D

TO: Mr. John W. Hooper #397  
FROM: Mr. Donald R. Hayes, Director  
Garage Department  
DATE: 20 July 1990  
SUBJECT: WRITTEN REPRIMAND

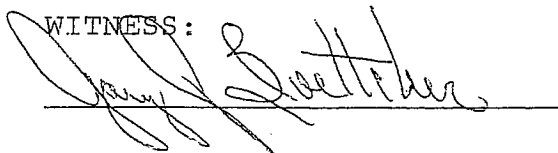
Mr. John Hooper is being given a Written Reprimand for the following violation of the Rules, Regulations or Policies of the Garage Department, Operating Instruction No. 6 - Leave Request Para. 4. which states "... the employee must call their duty section before the start of their scheduled shift start time...".

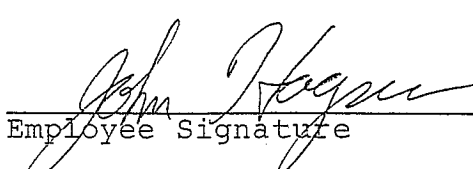
Mr. Hooper called in at 0720 hours 19 July 1990. His duty shift start time is 0700 hours.

THIS IS MR. Hooper's FIRST VIOLATION OF THIS OPERATING INSTRUCTION WITHIN 180 DAYS. THE 180-DAY PERIOD FOR THIS VIOLATION WILL END 15 JANUARY 1991.

This Reprimand has been read to Mr. Hooper.

WITNESS:

  
\_\_\_\_\_

  
Employee Signature

  
Donald R. Hayes, Director

## GARAGE DEPARTMENT

## CITY OF MONTGOMERY

## W R I T T E N R E P R I M A N D

TO: Mr. John W. Hooper #397  
FROM: Mr. Donald R. Hayes, Director  
Garage Department  
DATE: 06 January 1989  
SUBJECT: WRITTEN REPRIMAND

Mr. John W. Hooper is being given a Written Reprimand for the following violation of the Rules, Regulations or Policies of the Garage Department, Operating Instruction No. 8 - TIME ACCOUNTING CARD Par. 6 - "Neglect or failure to clock in or out is considered a violation." On 05 January 1989, Mr. Hooper failed to clock out at his departure time (1530 Hours).

This reprimand has been read to Mr. Hooper.

WITNESS:

Robert F. Wade

John Hooper  
Employee Signature

Donald R. Hayes  
Donald R. Hayes, Director

M E M O R A N D U M

To: Mr. John W. Hooper #397  
Memorandum-for-Record  
From: Mr. Robert F. Wade, <sup>R.F.W.</sup> Garage Foreman  
Date: 14 July 1986  
Subject: Absenteeism

This will confirm the verbal counsel session held in my office on 11 July 1986.

You were made aware that your absentee record was above average for the period between 01 October 1985 through 11 July 1986.

During this period, you were absent from duty a total of 141.7 hours. In sixteen (16) separate occasions, six (6) were scheduled and ten (10) were unscheduled. You stated to me that you would take corrective action to change this pattern.

copy: Personnel File

FORM 54 PER

## INSURANCE PREMIUM RECOVERY AUTHORIZATION FORM

Date 1/9/04To: CITY OF MONTGOMERY, FINANCE DEPT.  
(Payroll Section)From: JOHN HOOPER

I certify by my signature that I have read and understand the following policy:

I acknowledge my employer's legal right to recover the cost of any premium paid by it to maintain my coverage in group health benefits during any period of unpaid leave under the following conditions:

1. I fail to return from leave at the expiration of the leave to which I am entitled; and
2. The reason I fail to return to work is not one of the following:
  - A. the continuation, recurrence, or onset of a serious health condition that entitles me to leave to care for a child, parent or spouse with a serious health condition, or if I am unable to perform the functions of my position due to my own serious health condition; or,
  - B. other conditions beyond my control prevent me from returning.

Date: 1/9/04 Name (Print) John HooperEmployee Number: 7397 Name (Sign) John Hooper

## INSURANCE PREMIUM REIMBURSEMENT AGREEMENT

I certify by my signature that I have read and agree to do the following:

If I fail to return from leave, for any reason other than 2-A or 2-B above, I agree to coordinate with the payroll section to develop a mutually acceptable schedule to reimburse my employer for the cost of any premium paid by it to maintain my coverage in group health benefits during any period of unpaid leave taken by me.

Date: 1/9/04 Name (Print) John HooperEmployee Number: 7397 Name (Sign) John Hooper

FORM 55 PER  
(WH-381)

EMPLOYER RESPONSE TO EMPLOYEE  
REQUEST FOR FAMILY OR MEDICAL LEAVE  
(Family and Medical Leave Act of 1993)

(DATE)

TO:

JOHN HOOPER  
(Employee's Name)

FROM:

CITY OF MONTGOMERY FLEET MANAGEMENT DEPT.  
(Name of appropriate employer representative)

SUBJECT: Request for Family/Medical Leave

On 1/9/04 you notified us of your need to take family/medical leave due to:  
(date)

☐ the birth of a child, or the placement of a child with you for adoption or foster care; or

☒ a serious health condition that makes you unable to perform the essential functions of your job; or

☐ a serious health condition affecting your ☐ spouse, ☐ child, ☐ parent, for which you are needed to provide care.

You notified us that you need this leave beginning on 1/9/04 and that you expect leave to  
continue until on or about 4/2/04  
(date) (date)

Except as explained below, you have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period for the reasons listed above. Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or (2) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

This is to inform you that: (check appropriate boxes; explain where indicated)


1. You are ☒ eligible ☐ not eligible for leave under the FMLA.
2. The requested leave ☐ will not be counted against your annual FMLA leave entitlement.
3. You ☒ will ☐ will not be required to furnish medical certification of a serious health condition. If required, you must furnish certification by 2/13/04 (insert date) (must be at least 15 days after you are notified of this requirement) or we may delay the commencement of your leave until the certification is submitted.



4. You may elect to substitute accrued paid leave for unpaid FMLA leave. We ☐ will ☐ will not require that you substitute accrued paid leave for unpaid FMLA leave. If paid leave will be used, the following conditions will apply: (Explain) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- 5(a). If you normally pay a portion of the premiums for your health insurance, these payments will continue during the period of FMLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows: (Set forth dates, e.g., the 10th of each month, or pay periods, etc. that specifically cover the agreement with the employee.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- (b). You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be canceled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work. We ☐ will ☒ will not pay your share of health insurance premiums while you are on leave.
- (c). We ☒ will ☐ will not do the same with other benefits (e.g., life insurance, disability insurance, etc.) while you are on FMLA leave. If we do pay your premiums for other benefits, when you return from leave you ☐ will ☐ will not be expected to reimburse us for the payments made on your behalf.
6. You ☒ will ☐ will not be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until certification is provided.
- 7(a). You ☐ are ☒ are not a key employee" as described in §825.218 of the FMLA regulations. If you are a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us.
- (b). We ☐ have ☒ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. (Explain (a) and/or (b) below. See §825.219 of the FMLA regulations.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
8. While on leave, you ☐ will ☒ will not be required to furnish us with periodic reports every \_\_\_\_\_ (indicate interval of periodic reports, as appropriate for the particular leave situation) of your status and intent to return to work (see §825.309 of the FMLA regulations). If the circumstances of your leave change and you are able to return to work earlier than the date indicated on the reverse side of this form, you ☐ will ☒ will not be required to notify us at least two work days prior to the date you intend to report for work.
9. You ☐ will ☒ will not be required to furnish recertification relating to a serious health condition. (Explain below, if necessary), including the interval between certifications as prescribed in §825.308 of the FMLA regulations.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## MEMORANDUM

To: John W. Hooper, Employee #397

From: Terry H. Gaddis, Director  
Fleet Management Department 

Date: April 13, 2004

Subject: Medical Retirement

As you were advised by memo dated April 8, 2004, you have exhausted your benefits under the Family Medical Leave Act and have no annual, sick or compensatory leave accumulated and were required to return to full duty status on 13 April 2004. While I am concerned about you, I must also be concerned about maintaining this department's production standards. As you are aware, any employee's continued absence not only creates a problem with maintaining daily production, it is also creates hardships on other employees. Based on our discussion, this memorandum will serve as an official notification that I am willing to assist you in obtaining a medical retirement for your continuing medical condition.

I have thoroughly reviewed your personnel records and see that you have had similar recurring medical problems as far back as June 1990. I also understand from our discussion, that your continued medical problems are currently preventing you from coming to work and performing your assigned duties. Therefore, if you feel that you can no longer come to work everyday and perform your assigned duties, I request that you submit a request for a medical retirement based on a medical doctor's recommendation by close of business April 20, 2004.

Should you not continue to come to work or do not provide a doctor's recommendation for medical retirement on the date specified, I will have no choice but to recommend termination of your employment with the City of Montgomery.

CC: Jeff Downes, Executive Assistant to the Mayor  
John Carnell, Risk Manager  
Eugene Knox, Jr., Assistant Director, Fleet Management  
Royce Albright, Superintendent, Automotive Division

Mail To:

1-800-325-4368

8:00 A.M. to 7:00 P.M.

CLAIM FORM

Colonial Life & Accident  
Insurance Company  
Post Office Box 1365

Eastern Standard Time  
Toll Free Claims Number

Has a Claim been filed before  
for this loss? ☐ Yes  
☐ No

Columbia, South Carolina 29202-1365

SIDE 1

**A** Policyholder  
1. Name first John middle West last Hogner Social Security Number 421-90-0925  
Street RT 1 Box 27A Home phone (205) 222-4043  
2. Address City LeFlore State AL Zip 36047 3. number (205) 241-2509 Date of Birth 9/18/61  
City LeFlore State AL Zip 36047 Work phone number (205) 241-2509 ext.  ☒ male ☐ female

☐ CHECK HERE IF NEW ADDRESSPolicy Number 1-7221-792-20

4. Patient first Dana middle Latha last Hogner Date of Birth 12/15/61 Age 32  
Patient Social Security Number - - -

5. This person is your wife (example self, wife, son, etc.) ☐ male ☒ female  
Is he/she a full-time student? ☐ yes ☒ no

6. This claim is for: ☐ Accident ☐ Wellness Screening ☐ Intensive Care ☒ Hospital Income ☐ Other  
☐ Sickness ☐ Cancer If claim is being filed for cancer, enclose pathology report.

**B** 7. What sickness or injury are you claiming? off taking care of kids while wife was in the hospital  
8. List all doctors who have treated you for this condition: Name/Address Dr. S. Duggan  
2024 Chestnut St. Montgomery AL 36106 Phone No. 265-3543  
9. Have you received treatment, medication or advice from a doctor in the past for this or a similar condition?  Date   
Name  Address  Phone No.   
10. If you were hospitalized: Date admitted 11-5-94 Date discharged 11-8-94 Name of hospital Jackson Hosp.  
Address  Phone No.

**IF ACCIDENTAL INJURY:**

11. (A) Date injured  (B) Where did it happen?  (C) Time of accident  ☐ am ☐ pm

12. (D) Tell us exactly how your accident happened

13. (E) ☐ on job ☐ off job (F) Did your injuries occur while you were working for pay or profit?

**C** 14. Dates unable to work 11-7-94 ☒ am ☐ pm to 11-10-94 ☐ am ☐ pm  
15. Dates confined to your house  ☐ am ☐ pm to  ☐ am ☐ pm  
16. Have you returned to your main (or principal) duties? Date returned part-time  Date returned full-time 11-11-94

**TO BE COMPLETED BY EMPLOYER:**

**D** 17. Name of Employer City of Montgomery Phone number of Employer (205) 241-2509  
18. Billing Control No. City Garage 19. Is Workers' Compensation being filed? N/A  
20. Dates employee unable to work 7 November 1994 ☒ am ☐ pm to 10 November 1994 ☐ am ☒ pm  
21. Date employee returned to his main (or principal) duties: Date returned part-time  Date returned full-time 11 Nov 94  
22. Employee's job title and duties Auto Mechanic 23. Did the accident occur while working for wage or profit? Not an accident--  
his wife was confined to hospital.  
24. Signed James H. Gabilin Date 29 November 1994 Title Director

**E** Alaska, Delaware, Idaho and Florida residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. (Florida — Felony of the third degree.)

**Authorization**

I have checked the above answers and they are correct. I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to Colonial Life & Accident Insurance Company or its legal representative, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used by Colonial Life & Accident Insurance Company to determine eligibility for benefits under an existing policy. Any information obtained will not be released by Colonial Life & Accident Insurance Company to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal service in connection with my claim, or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this authorization shall be as valid as the original. I AGREE this Authorization shall be valid for two and one-half years from the date shown below. I certify under penalty of perjury that my correct social security number is shown on this form.

Signed this 29 day of November, 19 94.

Signature of Patient

Signature of Policyholder

Colonial Life & Accident  
Insurance Company  
Post Office Box 1365  
Columbia, South Carolina 29202-1365

Eastern Standard Time  
Toll Free Claims Number

SIDE 1

Has a Claim been filed before ☐ Yes  
for this loss? ☒ No

A Policyholder  
1. Name first John middle West last Hogper Social Security Number 421-90-09  
Street RT 1 Box 27A Home phone  
2. Address RT 1 Box 27A number (205) 227-4043 Date of Birth 9/18/1961  
City hatchee State AL Zip 36047 Work phone  
number (205) 241-2511 ext. ☒ male ☐ female

☐ CHECK HERE IF NEW ADDRESSPolicy Number 172219140

4. Patient first John middle West last Hogper Date of Birth 9/18/1961 Age 3  
Patient Social Security Number 421-90-0925

5. This person is your Myself (example self, wife, son, etc.) ☒ male ☐ female  
Is he/she a full-time student? ☐ yes ☒ no

6. This claim is for: ☒ Accident ☐ Wellness Screening ☐ Intensive Care ☐ Hospital Income ☐ Other  
☐ Sickness ☐ Cancer If claim is being filed for cancer, enclose pathology report.

B 7. What sickness or injury are you claiming? Broken Arm

8. List all doctors who have treated you for this condition: Name/Address Dr Edward Palmer 1501 Forest Ave. Monticello  
36132 - 205-263-3544 Jackson Hospital ER + Dr. Daugherty Phone No. 264-9739

9. Have you received treatment, medication or advice from a doctor in the past for this or a similar condition? NO Date \_\_\_\_\_  
Name \_\_\_\_\_ Address \_\_\_\_\_ Phone No. \_\_\_\_\_

10. If you were hospitalized: Date admitted \_\_\_\_\_ Date discharged \_\_\_\_\_ Name of hospital \_\_\_\_\_  
Address \_\_\_\_\_ Phone No. \_\_\_\_\_

## IF ACCIDENTAL INJURY:

11. (A) Date injured 9-29-94 (B) Where did it happen? Home (C) Time of accident approx. 2:00 ☐ am ☒ pm  
12. (D) Tell us exactly how your accident happened while installing a bridge on my property I fell off  
the bridge into the creek bottom about 15 to 16 feet  
13. (E) ☐ on job ☒ off job (F) Did your injuries occur while you were working for pay or profit? no

C 14. Dates unable to work 29 August 1994 ☒ am ☐ pm to 9 September 1994 ☐ am ☒ pm

15. Dates confined to your house \_\_\_\_\_ ☐ am ☐ pm to \_\_\_\_\_ ☐ am ☐ pm

16. Have you returned to your main (or principal) duties? Date returned part-time \_\_\_\_\_ Date returned full-time \_\_\_\_\_

## TO BE COMPLETED BY EMPLOYER:

D 17. Name of Employer City of Montgomery Phone number of Employer (205) 241-2509

18. Billing Control No. City Garage 19. Is Workers' Compensation being filed? No

20. Dates employee unable to work 29 August 1994 ☒ am ☐ pm to 9 September 1994 ☐ am ☒ pm

21. Date employee returned to his main (or principal) duties: Date returned part-time \_\_\_\_\_ Date returned full-time 12 Sep 94

22. Employee's job title and duties AutoMech-Motorcy 23. Did the accident occur while working for wage or profit? No

24. Signed Jerry M. Goodwin Date 12 Sep 1994 Title Director, City Shops

E Alaska, Delaware, Idaho and Florida residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. (Florida — Felony of the third degree.)

## Authorization

I have checked the above answers and they are correct. I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medical related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor child and any other non-medical information of me or my minor children to give to Colonial Life & Accident Insurance Company or its legal representative any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used by Colonial Life & Accident Insurance Company to determine eligibility for benefits under an existing policy. Any information obtained will not be released by Colonial Life & Accident Insurance Company to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal service in connection with my claim, or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this authorization shall be as valid as the original. I AGREE this Authorization shall be valid for two and one-half years from the date shown below. I certify under penalty of perjury that my correct social security number is shown on this form.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_

Signature of Patient

Signature of Policyholder

## M E M O R A N D U M

TO: Payroll Clerk, Garage Department  
DATE: 21 JANUARY 1991  
SUBJECT: Overtime Designation

In accordance with Personnel Rule VIII, Section 2 and 3, dealing with Overtime and Legal Holidays -- Exerpt from Section 2, (a) (3), as follows: "The employee has the sole option, by stating in writing, prior to the time that overtime work is performed, of either accepting overtime pay or compensatory time."

Therefore, in lieu of the above, I understand that I have the option to either accept overtime pay or compensatory time, as I have designated by the placement of my signature on the appropriate line below.

HOOPER 397  
(TYPE EMPLOYEE'S LAST NAME) EMPLOYEE NO.

In accordance with Personnel Rule VIII, I elect to receive pay for any overtime hours worked.

\_\_\_\_\_  
Employee's Full Signature

In accordance with Personnel Rule VIII, I elect to credit any overtime hours worked to Compensatory Leave.

  
\_\_\_\_\_  
Employee's Full Signature

NOTE: I may elect to change my option at any future date by presenting a new letter reflecting my decision. All letters will remain in effect until changed by the employee.



OFFICIAL BUSINESS

## SENDER INSTRUCTIONS

Print your name, address and ZIP Code in the space below.

- Complete items 1, 2, 3, and 4 on the reverse.
- Attach to front of article if space permits, otherwise affix to back of article.
- Endorse article "Return Receipt Requested" adjacent to number.



PENALTY FOR PRIVATE  
USE, \$300

*Alabama*

RETURN  
TO



Print Sender's name, address, and ZIP Code in the space below.

Donald R. Hayes  
City of Montgomery  
934 N. Ripley  
Montgomery, AL 36104

90

Mr. John W. Hooper  
Rt. 1 Box 27-A  
Letohatchee, AL 36047

Dear Mr. Hooper:

This is to inform you that at the close of business today you will have remaining 11.3 hours of annual leave; 4.4 hours of sick leave; no compensatory time and no personal days. If these hours are used you will be placed in a leave without pay (LWOP) status and I will recommend your termination from City employment.

Sincerely,

*Donald R. Hayes*

Donald R. Hayes, Director  
Garage Department

MEMORANDUM

TO: Mayor Emory Folmar

FROM: Mr. Donald R. Hayes, Director *D. Hayes*  
Garage Department

DATE: 21 February 1990

SUBJECT: Death of a mother

Mr. John W. Hooper, one of our motorcycle mechanics, was notified at approximately 1000 hours this date that his mother had passed away.

Mrs. Opal Hooper lived in Huntsville, Al. She has been sick with cancer for the past five years. She died in her sister's home in Huntsville.

The above is the only information we have at this time.

Mr. John W. Hooper  
Rt. 1 Box 27-A  
Letohatchee, Al 36047  
Phone: 227-4790

DRH/cm

cc: Mrs. A. Folmar

M E M O R A N D U M

TO: All Department Personnel

FROM: Mr. Donald R. Hayes, Director  
Garage Department

DATE: 05 January 1989

SUBJECT: Sick Leave

*D. Hayes*

Six (6) of our employees completed Calendar Year 1988 without taking any time off on sick leave.

ARTHUR, WILLIE  
COKER, WILLIAM C.  
FLYNN, JAMES D.  
HOOPER, JOHN W. (2nd year in a row)  
QUATES, JR., DAVID  
WRIGHT, WILLIE

In order to have been considered, an individual had to be employed for the full year of 1988.

My personal thanks to each of you for such a notable attendance record. Keep up the good work---and let's see the list grow in 1989.

/jfb

cc: Personnel File  
Arthur  
Coker  
Flynn  
Hooper  
Quates  
Wright



## M E M O R A N D U M

TO: All Department Personnel

FROM: Mr. Donald R. Hayes, Director  
Garage Department

DATE: 18 September 1987

SUBJECT: Sick Leave

The following Rule VIII, Section 5 - Sick Leave (C), is quoted from the City and County of Montgomery Personnel Department Rules and Regulations:

Sick Leave may be granted only for absence due to personal illness, maternity, legal quarantine, attendance upon members of the immediate family whose illness requires the care of the employee, or death in the immediate family of the employee. Immediate family is hereby defined to include spouse, children, parents, grandparents, parents-in-law, and siblings. Unusually strong ties with other other relatives may be recognized for leave purposes upon written justification by the employee and approval of the appointing authority and/or Personnel Director. An employee claiming sick leave may be required by the appointing authority to file a certificate from a physician stating the kind and nature of sickness or injury, that the employee was incapacitated for work for the period of absence, that the employee is physically unable to perform duties or that the employee has no contagious disease that might jeopardize the health of other employees, or that the employee is required to provide care for an ill family member.

As stated in this rule, an employee claiming sick leave may be required to file a certificate from a physician. This is the KEY PHRASE in the rule. Should you be required or directed to obtain a physician's certificate, the physician must comply with this rule -- state the kind and nature of sickness or injury, etc., etc., as outlined above. The certificate must include the date(s) the employee was absent from work and under the doctor's care. In other words, a mere doctor's stamp, nurse's signature, etc. will not be accepted. It is incumbent upon the employee that this personnel rule be followed to the letter.

NOTE: ALSO SEE GARAGE DEPARTMENT OPERATING INSTRUCTION NO. 6  
SUBJECT: LEAVE REQUEST

I Acknowledge receipt and understanding of this memorandum.

  
\_\_\_\_\_  
Employee Signature  
John W. Hooper

399  
\_\_\_\_\_  
Employee #

9-21-87  
\_\_\_\_\_  
Date

YOU MAY WANT TO CARRY THESE INSTRUCTIONS ON YOUR PERSON.

M E M O R A N D U M

TO: All Department Personnel

FROM: Mr. Donald R. Hayes, Director *D. Hayes*  
Garage Department

DATE: 05 January 1987

SUBJECT: Outstanding Attendance

Three (3) individuals completed calendar year 1987 without taking any time off on SICK LEAVE.

Mr. Jesse J. Boyd  
Mr. John W. Hooper  
Mr. Eugene Knox, Jr. (2nd year in a row)

In order to have been considered, an individual had to be employed for the full year of 1987.

My personal thanks for such a notable attendance record. Keep up the good work --- and let's see the list grow!

DRH:crs

cc: Personnel File:

Boyd, J. J.  
Hooper, J. W.  
Knox, E., Jr.

TV

**MONTGOMERY FAMILY MEDICINE, P.C.**

Brian W. Elrod, M.D.  
Eric W. Graves, M.D.

8190 Seaton Place  
Montgomery, AL 36116  
(334) 396-9100

Jeffrey W. Mathis, M.D.  
A. Stuart Hendon, M.D.  
Daniel L. Moore, M.D.

**DR. APPOINTMENT VERIFICATION FORM**

John Hoopes 9/10/03  
Patient Name Date Appointment Time

PATIENT MAY RETURN TO WORK/SCHOOL ON: 9/11/03  
Date

Comments/Special Instructions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A. Stuart Hendon

Physician Signature

9/10/03  
Date



## MONTGOMERY FAMILY MEDICINE, P.C.

Brian W. Elrod, M.D.  
Eric W. Graves, M.D.

8190 Seaton Place  
Montgomery, AL 36116  
(334) 396-9100

Jeffrey W. Mathis, M.D.  
A. Stuart Hendon, M.D.  
Daniel L. Moore, M.D.

## DR. APPOINTMENT VERIFICATION FORM

John Hooper 7/31/07  
Patient Name Date Appointment Time

PATIENT MAY RETURN TO WORK/SCHOOL ON: 8/4/03

Date

Comments/Special Instructions:

Excused for 7/31/03 & 8/01/03

A. Stuart Hendon

Physician Signature

7/31/03  
Date

te to return to work or school

John Hooper  
Under my care from 16 July 91 to 19 July 91  
Patient of Amie Gooden  
Return to work/school on 20 July 91

**GEOFFREY W. DAUGHERTY, M.D.**

1722 Pine St. Suite 903

Montgomery, AL 36106-4103

DISTA PRODUCTS COMPANY, DIVISION OF  
ELI LILLY AND COMPANY, INDIANAPOLIS, INDIANA 46285

3 IN U.S.A. 50101-4550 APRIL, 1985 © 1985, DISTA PRODUCTS COMPANY

Certificate to return to work or school

Mr.  
Ms.  
Mrs.  
Miss

John Hooper

has been under my care from 29 July 91 to —  
for the treatment of Bronchitis & Sinusitis  
and is able to return to work/school on 30 July 91  
Remarks —

Dr.

**GEOFFREY W. DAUGHERTY, M.D.**

Address 1722 Pine St. Suite 903 Date —

Montgomery, AL 36106-4103



DISTA PRODUCTS COMPANY, DIVISION OF  
ELI LILLY AND COMPANY, INDIANAPOLIS, INDIANA 46285

50-KX-1901-2 PRINTED IN U.S.A. 520101-4550 APRIL, 1985 © 1985, DISTA PRODUCTS COMPANY

Mr. John Hooper  
Mrs. \_\_\_\_\_  
Ms. \_\_\_\_\_

Has been under my care from 2-20-02 to 2-25-02

and is able to return to work/school on Monday 2-25-02

Remarks: pt. has been sick and unable to work.

THE OTORHINOLARYNGOLOGY ASSOCIATES

Dr. R. J. [Signature] Phone 281-6227  
Address \_\_\_\_\_ Date 2-22-02

John W. Hooper  
 been under my care from \_\_\_\_\_ to \_\_\_\_\_  
 is able to return to work/school on \_\_\_\_\_  
 Remarks Seen in office this afternoon  
 on medical evaluation  
 Dr. P.W. Daugherty Phone 264-9739  
 Address 303 S. Ripley St Date 29 Aug 90  
 Eli Lilly Industries, Inc. • Carolina, Puerto Rico 00630  
 Subsidiary of Eli Lilly and Company • Indianapolis, Indiana 46285

John W. Hooper ← Presumed File  
 has been under my care from \_\_\_\_\_ to \_\_\_\_\_  
 and is able to return to work/school on 06 Sept 90  
 Remarks Seen in my office 4pm today with  
 abdominal pain due to functional bowel  
 syndrome  
 Dr. P.W. Daugherty, M.D. Phone 264-9739  
 Address 303 S. Ripley St Date 05 Sept 90  
 Eli Lilly Industries, Inc. • Carolina, Puerto Rico 00630  
 Subsidiary of Eli Lilly and Company • Indianapolis, Indiana 46285

Certificate to return to work or school

John W. Hooper  
 been under my care from \_\_\_\_\_ to \_\_\_\_\_  
 is able to return to work/school on 27 Aug 90  
 Remarks Came to my office at this date -  
 abdominal pain that had greatly  
 improved  
 Dr. P.W. Daugherty Phone 264-9739  
 Address 303 S. Ripley St Date 24 Aug 90  
 Montgomery, AL 36104  
 Eli Lilly Industries, Inc. • Carolina, Puerto Rico 00630  
 Subsidiary of Eli Lilly and Company • Indianapolis, Indiana 46285

Certificate to return to work or school

Mr. John W. Hooper  
 Mrs.  
 Ms.  
 has been under my care from 27 Aug 90 to \_\_\_\_\_  
 and is able to return to work/school on \_\_\_\_\_  
 Remarks Seen in office today for disabling  
 abdominal pain and nausea  
 Dr. P.W. Daugherty Phone 264-9739  
 Address \_\_\_\_\_ Date 27 Aug 90  
 Eli Lilly Industries, Inc. • Carolina, Puerto Rico 00630  
 Subsidiary of Eli Lilly and Company • Indianapolis, Indiana 46285

Certificate to return to work or school

John Hooper  
 been under my care from 4-7-92 to \_\_\_\_\_  
 is able to return to work/school on 4-8-92  
 Remarks \_\_\_\_\_  
 Dr. R.J. Lawrence Phone 281-632  
 Address \_\_\_\_\_ Date 4-7-92  
 ENTORHINOLARYNGOLOGY  
 Eli Lilly Industries, Inc. • Carolina, Puerto Rico 00630  
 Subsidiary of Eli Lilly and Company • Indianapolis, Indiana 46285

Certificate to return to work or school

Mr. John Hooper  
 Mrs.  
 Ms.  
 has been under my care from \_\_\_\_\_ to \_\_\_\_\_  
 and is able to return to work/school on \_\_\_\_\_  
 Remarks Seen in office for medical  
 evaluation & treatment  
 Dr. GEOFFREY W. DAUGHERTY, M.D. Phone 264-9739  
 Address 1722 Pine St. Suite 903  
 Montgomery, AL 36106-4103  
 Date 06 May 92  
 Eli Lilly Industries, Inc. • Carolina, Puerto Rico 00630



Mr  
Mrs  
MsJohn W. Hopperhas been under my care from 01 Apr 92 to \_\_\_\_\_

and is able to return to work/school on \_\_\_\_\_

Remarks

Seen in office today for  
medical treatment

Dr

Phone

201-9739

GEOFFREY W. DAUGHERTY, M.D.

Address 1722 Pine St. Suite 903

Date

01 Apr 92

Eli Lilly Industries, Inc. • Carolina, Georgia 30630

A Subsidiary of Eli Lilly and Company • Indianapolis, Indiana 46285

60-CR-0131-3 PRINTED IN USA 700955-1187100

## Medically Excused Absence

This is to confirm that

John W. Hopper

has been under my care

for

4-2-92, Thursdayear inf. and sinus problems

from

4-2-92

to

4-2-92

The patient's absence was medically advised.

signature

Gise Jossion / R.D. Gore, MD

PD-07-R-2359-P-1 (2-86)

## Certificate to return to work

72

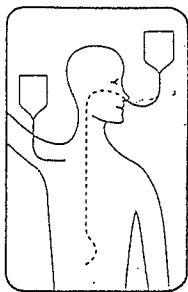
Name John Hopper  
has been under my care from 5-20-97 to 5-23-97  
and will be able to return to work on 5-26-97  
Nature of illness or injury \_\_\_\_\_

☐ Restrictions☐ Light Work

Comments \_\_\_\_\_

THE OTORHINOLARYNGOLOGY ASSOCIATESDr. \_\_\_\_\_ Phone 281-6327Address \_\_\_\_\_ Date 5-23-97(28)





*Nutritional Support Consultants, P. C.*

Research • Education • Patient Care

③

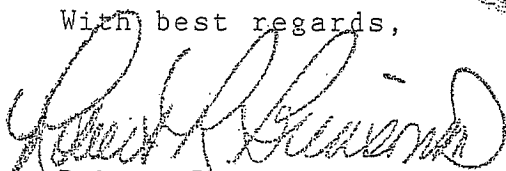
Robert R. Brinson, M.D.  
*Director*

October 26, 1990

To whom it may concern:

John Hooper was seen today in our office for evaluation of severe abdominal pain. If you have any questions concerning his medical care, please feel free to call our office.

With best regards,



Robert R. Brinson, M.D.

K/18

**ROBERT R. BRINSON, M.D.**

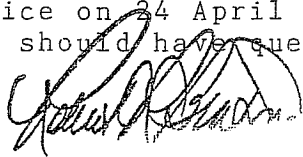
2109 Taylor Road  
Montgomery, Alabama 36117  
(334) 271-1205

*Diplomate, American Board of Internal Medicine  
Diplomate, Subspecialty Board, Gastroenterology  
Fellow, American College of Nutrition*

*Gastroenterology  
Clinical Nutrition  
Hyperalimentation*

TO WHOM IT MAY CONCERN

This is to confirm that John Hooper was seen in  
my office on 24 April 1996 for a scheduled appointment.  
If you should have questions, please contact my office.



---

Robert R. Brinson, M. D.

## Certificate to return to work or school

Mr.  
Mrs.  
Miss

John Hager

has been under my care from

4/17

to 4/18

and is able to return to work/school on

4-19-96

Remarks

seen in office 4/17.

NAUSEA

ABDOMINAL PAIN

GEOFFREY W. DAUGHERTY, M.D.

1722 Pine St. Suite 903

Dr.

Montgomery, AL 36106-4103

Phone

334/264-9739

Address

Date

4-18-96

Eli Lilly and Company • Indianapolis, Indiana 46285

MISS John Hooper  
has been under my care from 4-11-96 to 4-11-96  
for the treatment of Return to work 4-15-96  
and is able to return to work/school on 4-11-96  
Remarks \_\_\_\_\_

Restrictions: ☐ Light work ☐ None  
Physical education: ☐ may take ☐ limited ☐ none  
☐ Other observations: \_\_\_\_\_

Required to take medication during active hours: ☐ Yes ☐ No

Medication: AMES ALEXANDER  
Dr. AMES ALEXANDER 300 Taylor Rd. Suite 903  
Montgomery, AL 36117  
(205) 270-8375  
Address \_\_\_\_\_ Date 4-12-96

Compliments of Advil 6083-05

MISS John Hooper  
has been under my care from 4-11-96 to 4-15-96  
for the treatment of Return to work 4-15-96  
and is able to return to work/school on 4-15-96  
Remarks \_\_\_\_\_

Dr. GEOFFREY W. DAUGHERTY, M.D. 1722 Pine St. Suite 903  
Address Montgomery, AL 36106-4103  
Date 19 April 96

**ELI LILLY AND COMPANY**  
INDIANAPOLIS, INDIANA 46285  
60-KX-1901-2 PRINTED IN U.S.A. 570161-0550 APRIL 1995 © 1995, ELI LILLY AND COMPANY

# **Indicate to return to work**

Name John Hooper  
has been under my care from 04-22-96 to 04-22-96  
and will be able to return to work on 04-23-96

Nature of illness or injury \_\_\_\_\_

☐ Restrictions ☐ Light Work

Comments \_\_\_\_\_

Dr. R. B. Clark, M.D. Phone 281-6321  
Address \_\_\_\_\_ Date 04-22-96

Please see complete Prescribing Information at the back of this pad.

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E2-A060-1-94

## **Certificate to return to work or school**

Mr. JOHN W. HOOPER  
Mrs. \_\_\_\_\_  
Miss \_\_\_\_\_

has been under my care from 17 April 96 to \_\_\_\_\_

and is able to return to work/school on 18 April 96

Remarks Has moment vomiting

Dr. GEOFFREY W. DAUGHERTY, M.D. Phone \_\_\_\_\_  
Address 1722 Pine St. Suite 903  
Montgomery, AL 36106-4103 Date \_\_\_\_\_  
334/264-9739

Eli Lilly and Company • Indianapolis, Indiana 46285

60-CR-0131-0 PRINTED IN U.S.A. 200026-1161100 NOVEMBER, 1991

## **Certificate to return to work**

Name John Hooper  
has been under my care from 4-11-96 to 4-15-96  
and will be able to return to work on 4-16-96

Nature of illness or injury \_\_\_\_\_

☐ Restrictions ☐ Light Work

Comments \_\_\_\_\_

Dr. James W. Clark Phone \_\_\_\_\_  
Address \_\_\_\_\_ Date 4/15/96

Please see complete Prescribing Information at the back of this pad.

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E2-A060-1-94

ACCOUNT# 4193643 M/R # 09-02-97 HOSPITAL & CLINIC, INC.  
 HOOPER, JOHN WEST 35 FOREST AVENUE  
 SEX - M BORN: 09/18/61 F/C - B JTGOMERY, AL 36106  
 BRINSON, ROBERT ROOM: CTIONS - ENDOSCOPY PATIENTS



\_\_\_\_\_  
 Patient Name Doctor  
 Return to Dr. \_\_\_\_\_ office on \_\_\_\_\_ Date \_\_\_\_\_  
 at \_\_\_\_\_ Time \_\_\_\_\_  
 Return to Jackson Hospital Outpatient Service on \_\_\_\_\_ Date \_\_\_\_\_ at \_\_\_\_\_ Time \_\_\_\_\_  
 for \_\_\_\_\_ Procedure \_\_\_\_\_

THE FOLLOWING CHECKED INSTRUCTIONS ARE SPECIFIC FOR YOUR PROCEDURE

1. ☒ Notify your doctor if you have any of the following symptoms:
  - a. ☒ More than 1 teaspoon of bright red blood in your bowel movement.
  - b. ☒ Fever over 100°.
  - c. ☒ Severe abdominal pain.
 If you are unable to reach your doctor, call Jackson Hospital at 293-8000 and ask the switchboard operator to locate him.
2. ☒ You may experience gas pains and cramps after your examination. If the discomfort does not go away in 6-12 hours, notify your doctor.
3. ☒ No alcoholic beverages or tranquilizers for 24 hours.
4. ☒ Rest at home today.
5. ☒ Have a responsible adult accompany you when out of the bed for the next 4 hours or until you do not experience any dizziness.
6. ☒ Do not drive for 24 hours.
7. ☒ Resume normal activities tomorrow.
8. ☒ Resume usual diet in one hour or when your throat is no longer numb.
9. ☐ Follow \_\_\_\_\_ diet as instructed by the dietitian.
10. ☐ No caffeine (coffee, coke, tea).
11. ☐ No aspirin or any medication containing aspirin.
12. ☐ No nicotine.
13. ☐ You may gargle with a saline gargle (1 tsp. salt with 2 cups of warm water) or use chloroseptic lozenges for throat discomfort.
14. ☐ You may use a warm, wet compress to your IV site for any redness or discomfort. If redness persists, call your physician.
15. ☒ If your doctor removed a polyp or tissue (biopsy) for further examination, he will notify you by phone or in writing as soon as he receives the results. Your doctor usually receives this report in 24-48 hours after the tissue is examined by a pathologist.
16. ☐ Take the following medications as ordered by your physician.

17. ☐ Other specific instructions: Repeat exam in 1 yr

I acknowledge the receipt and understanding of these instructions. I was informed by

Dr. Robert Brinson  
 Name of Practitioner

Witness

Signature of Patient or Patient Representative

ACCOUNT# 4192007 M/R # 09-02-97 JACOBSON HOSPITAL & CLINIC, INC.  
 HOOPER, JOHN WEST 1235 FOREST AVENUE  
 SEX - M BORN: 09/18/61 F/C - B MONTGOMERY, AL 36106  
 BRINSON, ROBERT ROOM: INSTRUCTIONS - ENDOSCOPY PATIENTS

Return to Dr. \_\_\_\_\_ office on \_\_\_\_\_ Date \_\_\_\_\_  
 at \_\_\_\_\_ Time \_\_\_\_\_  
 Return to Jackson Hospital Outpatient Service on \_\_\_\_\_ Date \_\_\_\_\_ at \_\_\_\_\_ Time \_\_\_\_\_  
 for \_\_\_\_\_ Procedure \_\_\_\_\_

## THE FOLLOWING CHECKED INSTRUCTIONS ARE SPECIFIC FOR YOUR PROCEDURE

1. ☒ Notify your doctor if you have any of the following symptoms:
  - a. ☒ More than 1 teaspoon of bright red blood in your bowel movement.
  - b. ☒ Fever over 100°.
  - c. ☒ Severe abdominal pain.
 If you are unable to reach your doctor, call Jackson Hospital at 293-8000 and ask the switchboard operator to locate him.
2. ☒ You may experience gas pains and cramps after your examination. If the discomfort does not go away in 6-12 hours, notify your doctor.
3. ☒ No alcoholic beverages or tranquilizers for 24 hours.
4. ☒ Rest at home today.
5. ☒ Have a responsible adult accompany you when out of the bed for the next 4 hours or until you do not experience any dizziness.
6. ☒ Do not drive for 24 hours.
7. ☒ Resume normal activities tomorrow.
8. ☒ Resume usual diet in one hour or when your throat is no longer numb.
9. ☐ Follow \_\_\_\_\_ diet as instructed by the dietitian.
10. ☐ No caffeine (coffee, coke, tea).
11. ☐ No aspirin or any medication containing aspirin.
12. ☐ No nicotine.
13. ☒ You may gargle with a saline gargle (1 tsp. salt with 2 cups of warm water) or use chloroseptic lozenges for throat discomfort.
14. ☒ You may use a warm, wet compress to your IV site for any redness or discomfort. If redness persists, call your physician.
15. ☒ If your doctor removed a polyp or tissue (biopsy) for further examination, he will notify you by phone or in writing as soon as he receives the results. Your doctor usually receives this report in 24-48 hours after the tissue is examined by a pathologist.
16. ☒ Take the following medications as ordered by your physician.

*Continue taking - see appendix 110*  
*12/15/05*

17. ☐ Other specific instructions: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

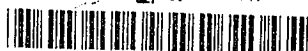
I acknowledge the receipt and understanding of these instructions. I was informed by K. Brinson Name of Practitioner

[Signature] Witness [Signature] Signature of Patient or Patient Representative

ACCOUNT# 4192707 M/R # 09-02-97 JACKSON HOSPITAL & CLINIC, INC.  
 HOOPER, JOHN WEST 1235 FOREST AVENUE  
 SEX - M BORN: 09/18/61 F/C - B MONTGOMERY, AL 36106

BRINSON, ROBERT ROOM:

# INSTRUCTIONS - ENDOSCOPY PATIENTS



Patient Name

Doctor

Return to Dr. \_\_\_\_\_ office on \_\_\_\_\_ Date \_\_\_\_\_

at \_\_\_\_\_ Time \_\_\_\_\_

Return to Jackson Hospital Outpatient Service on \_\_\_\_\_ Date \_\_\_\_\_ at \_\_\_\_\_ Time \_\_\_\_\_

for \_\_\_\_\_ Procedure \_\_\_\_\_

## THE FOLLOWING CHECKED INSTRUCTIONS ARE SPECIFIC FOR YOUR PROCEDURE

1. ☒ Notify your doctor if you have any of the following symptoms:
  - a. More than 1 teaspoon of bright red blood in your bowel movement.
  - b. Fever over 100°.
  - c. Severe abdominal pain.
 If you are unable to reach your doctor, call Jackson Hospital at 293-8000 and ask the switchboard operator to locate him.
2. ☒ You may experience gas pains and cramps after your examination. If the discomfort does not go away in 6-12 hours, notify your doctor.
3. ☒ No alcoholic beverages or tranquilizers for 24 hours.
4. ☒ Rest at home today.
5. ☒ Have a responsible adult accompany you when out of the bed for the next 4 hours or until you do not experience any dizziness.
6. ☒ Do not drive for 24 hours.
7. ☒ Resume normal activities tomorrow.
8. ☒ Resume usual diet in one hour or when your throat is no longer numb.
9. ☐ Follow \_\_\_\_\_ diet as instructed by the dietitian.
10. ☐ No caffeine (coffee, coke, tea).
11. ☐ No aspirin or any medication containing aspirin.
12. ☒ No nicotine.
13. ☒ You may gargle with a saline gargle (1 tsp. salt with 2 cups of warm water) or use chloroseptic lozenges for throat discomfort.
14. ☒ You may use a warm, wet compress to your IV site for any redness or discomfort. If redness persists, call your physician.
15. ☐ If your doctor removed a polyp or tissue (biopsy) for further examination, he will notify you by phone or in writing as soon as he receives the results. Your doctor usually receives this report in 24-48 hours after the tissue is examined by a pathologist.

16. ☐ Take the following medications as ordered by your physician:  
Any questions - call Dr. Brinson's office 271-1205

17. ☐ Other specific instructions: Return for colonoscopy on March 24 at 7:00 AM. Take all of prep. Night before. Don't eat or drink after midnight night before. Bring a / call.

I acknowledge the receipt and understanding of these instructions. I was informed by Dr. Robert Brinson Name of Practitioner

Witness

Signature of Patient or Patient Representative

42

①

PATIENT INSTRUCTIONS FOR ERCP

You have been scheduled for an ERCP. ERCP means we will be passing the scope orally down to the intestine where the bile duct and pancreatic duct empty into the intestine at a place called the papilla. A catheter will then be passed into this opening and dye will be injected into both ducts to make X-Rays of these ducts to see if there is any evidence of abnormalities.

There are minor risks with this procedure, as with any procedure, which would include infection, pancreatitis (inflammation of the pancreas), bleeding or perforation. All of these risks are extremely low.

You have been scheduled at the following Hospital: Jackson  
Hospital @ 7:30 on this date: May 13.

DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT ON THIS DATE.

If you have any further questions, please call my office at 271-1205.

②

Small Bowel Follow Through  
5/8/96 Wed. 8:45 #203 Dodge Building



g

**ROBERT R. BRINSON, M.D.**

2109 Taylor Road  
Montgomery, Alabama 36117  
(334) 271-1205

*Diplomate, American Board of Internal Medicine  
Diplomate, Subspecialty Board, Gastroenterology  
Fellow, American College of Nutrition*

*Gastroenterology  
Clinical Nutrition  
Hyperalimentation*

TO WHOM IT MAY CONCERN

John Hooper has been under my care for an illness 7, 8 and 9 of May.

He was unable to perform his regular employment duties.

  
Robert R. Brinson, M. D.

**BIAXIN**<sup>TM</sup>  
clarithromycin

## Certificate to return to work

Name JOHN W. HOOPER  
has been under my care from 18 MAR 96 to 27 MAR 96  
and is able to return to work on 27 MAR 96  
Nature of illness or injury MILD CARPEL TUNNEL SYNDROME  
☐ restrictions ☒ no restrictions  
Comments MAY OCCASIONALLY GET NUMB HANDS  
WHEN USING HARD PULLING ON TOOLS  
Dr. G.W. DAUGHERTY Phone 264-9739  
Address 1722 PINE ST Date 27 Mar 96  
MONTGOMERY, AL 36106

Mr. Hooper came back to work on 10-21-94  
and said he felt like working even  
tho the Dr. recommended he not return  
to work until 10-24-94.

*J*  
10-21-94

Certificate to Return to School or Work

John Hooper  
 under my care from 26 July 95 to \_\_\_\_\_  
 to return to work/school on \_\_\_\_\_  
Seen in office for  
medical treatment

**KEY W. DAUGHERTY, M.D.** Phone 264-9739  
 722 Pine St. Suite 903  
 Montgomery, AL 36106-4103 Date 26 July 95  
 205/264-9739  
 Company • Indianapolis, Indiana 46285

60-CR-0131-0 PRINTED IN U.S.A. 200026-1181100 NOVEMBER, 1991

Date: 7-19-95  
 Name: Donna Hooper  
 is my patient and has been under my care from 7-19-95 to \_\_\_\_\_  
 and is able to return to school/work on \_\_\_\_\_  
 Remarks: John Hooper had to  
bring her to our office  
 Dr. THE OTORHINOLARYNGOLOGY ASSOCIATES  
 (Signature)  
 Address: \_\_\_\_\_  
 Telephone: 281-6327

to return to work

Hooper  
 care from 11-2-95 to 11-2-95  
 return to work on 11-3-95  
 injury side effects of medicine  
 Light Work

**OTOLARYNGOLOGY ASSOCIATES**  
 Phone 281-632  
Normandie Dr. Date 11-2-95

**ICEF®** (CEFADROXIL MONOHYDRATE, USP)

Duricef may be given QD or BID for skin/skin structure infections in adults, uncomplicated UTI in adults, and pharyngitis/tonsillitis in both adults and children. For more serious UTI in adults, and for UTI and skin/skin structure infections in children, BID is the prescribed dosing regimen.  
 © 1994, Bristol-Myers Squibb Company, Princeton, N.J. 08543 U.S.A.

Certificate to return to work or school

Mr. John Hooper  
 Mrs. \_\_\_\_\_  
 Miss \_\_\_\_\_  
 has been under my care from 20 Mar 95 to \_\_\_\_\_  
 and is able to return to work/school on 21 Mar 95  
 Remarks: Has viral respiratory  
infection  
 Dr. GEOFFREY W. DAUGHERTY, M.D. Phone \_\_\_\_\_  
 Address: 1722 Pine St. Suite 903 Date 20 Mar 95  
Montgomery, AL 36106-4103  
205/264-9739  
 Eli Lilly and Company • Indianapolis, Indiana 46285

60-CR-0131-0 PRINTED IN U.S.A. 200026-1181100 NOVEMBER, 1991

Certificate to Return to School or Work

Name John Hooper  
 is my patient and has been under my care from 9-26-95 to \_\_\_\_\_  
 and is able to return to work/school on 9-27-95  
 Remarks: \_\_\_\_\_  
 Dr. THE OTORHINOLARYNGOLOGY ASSOCIATES Date 9-26-95  
 Address: \_\_\_\_\_  
 Telephone: 281-6327

John W. Hooper  
 under my care from 01 July 94 to  
 to return to work/school on 02 July 94  
Has mild symptoms

**Y W. DAUGHERTY, M.D.**  
 2 Pine St. Suite 903 Phone  
 omery, AL 36106-4103  
205/264-9739 Date 01 July 94  
 stries, Inc. • Carolina, Puerto Rico 00630  
 of Eli Lilly and Company • Indianapolis, Indiana 46285

60-CR-0131-2 PRINTED IN USA 600389-38675 MARCH 1986

Mr  
 Mrs  
 Ms John Hooper  
 has been under my care from 29 Aug 94 to  
 and is able to return to work/school on 05 Sept 94  
 Remarks Has a fracture of left wrist  
sustained 29 Aug 94 - will need  
light duty while in splint or cast

**GEOFFREY W. DAUGHERTY, M.D.**  
 1722 Pine St. Suite 903  
 Address Montgomery, AL 36106-4103 Date 30 Aug 94  
205/264-9739  
 Eli Lilly Industries, Inc. • Carolina, Puerto Rico 00630  
 A Subsidiary of Eli Lilly and Company • Indianapolis, Indiana 46285

60-CR-0131-2 PRINTED IN USA 600389-38675 MARCH 1986

te to return to work or school K

John Hooper  
 der my care from 12/28/94 to 1/6/94  
 o return to work/school on 12/29/94  
Has been in for an office  
today will have an  
lient procedure on Jan 6  
may return Jan 7, 1995  
1+ Bunsen Phone 205/77-1205

09 Taylor Rd Date 12/28/94  
 ries, Inc. • Carolina, Puerto Rico 00630  
 Eli Lilly and Company • Indianapolis, Indiana 46285

60-CR-0131-3 PRINTED IN USA 700955-1187100

# MEDICALLY EXCUSED ABSENCE

is is to confirm that John Hooper  
 s been under my care for Bronchitis

THE OTORHINOLARYNGOLOGY ASSOCIATES  
 m. 7-5-94 to 7-8-94

patient's absence  
 s medically advised. R. Brian Collins MD  
 signature [Signature]

**JACKSON HOSPITAL & CLINIC, INC.**  
 1235 Forest Avenue • Montgomery, AL 36106 • (205) 293-8000

For John Hooper Age 49  
 Address [Address] Date 6/9

**Rx NOT FOR CONTROLLED DRUGS**  
To whom it may concern  
Mr Hooper was seen at Jackson Hooper  
for ERD. Please excuse him  
from work

Reg. No. \_\_\_\_\_  
 Refill 0 1 2 3 4 5  
 \_\_\_\_\_ M.D.  
 DISPENSE AS WRITTEN PRODUCT SELECTION PERMITTED

## Certificate to return to work or school

Mr  
Mrs  
Ms*John Harper*has been under my care from 22 Feb 95 to \_\_\_\_\_

and is able to return to work/school on \_\_\_\_\_

Remarks Seen in ER 21 Feb 95  
in my office 22 Feb 95GEOFFREY W. DAUGHERTY, M.D.  
1722 Pine St. Suite 903  
Montgomery, AL 36106  
Phone 205/264-9739Dr. Geoffrey W. Daugherty, M.D.  
Address \_\_\_\_\_  
Date 22 Feb 95Eli Lilly Industries, Inc. • Carolina, Puerto Rico 00630  
Subsidiary of Eli Lilly and Company • Indianapolis, Indiana 46285ON 2-22-95 60-CR-0131-3 PRINTED IN USA 700955-1187100☒ IF YOU BECOME WORSE OR DO NOT GET BETTER SEE YOUR PRIVATE PHYSICIAN OR GO TO THE ER OF THE DAY☐ YOU MAY RETURN TO WORK OR SCHOOL TODAY

LIMITATIONS/REMARKS \_\_\_\_\_

☒ YOU MAY NOT RETURN TO WORK OR SCHOOL TODAYYOU MAY RETURN ON Friday 2-24-95

LIMITATIONS/REMARKS \_\_\_\_\_

## OTHER SPECIFIC INSTRUCTIONS

**IMPORTANT NOTICE:** YOUR X-RAY HAS BEEN READ AND REVIEWED. FINAL REVIEW BY THE RADIOLOGIST IS MADE THE FOLLOWING DAY. IT IS IMPORTANT THAT YOU REQUEST YOUR PHYSICIAN TO CALL THE X-RAY DEPARTMENT TOMORROW AFTER 11:00 A.M. FOR THE FINAL X-RAY INTERPRETATION. 293-8000, EXT. 8182.

I HEREBY ACKNOWLEDGE RECEIPT OF ABOVE PRINTED INSTRUCTIONS:

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

DATE \_\_\_\_\_

SIGNED *John Harper*

MD OR NURSE

**PLEASE NOTE:** TREATMENT GIVEN IN THE EMERGENCY SERVICE IS OFFERED AS EMERGENCY FIRST CARE ONLY.

FOLLOW-UP TREATMENT BY A PHYSICIAN MAY BE IMPORTANT FOR YOUR SAFETY. YOU ARE URGED TO FOLLOW CAREFULLY THE INSTRUCTIONS GIVEN ON THIS SHEET.

CLINIC, INC.

1ue

ia 36106



## TION SHEET

DATE OF SERVICE 2-24-95

FOLLOW THE WRITTEN INSTRUCTION SHEET WHICH HAS BEEN GIVEN TO YOU TO HELP IN TREATMENT OF YOUR ILLNESS OR INJURY:

## YOU HAVE BEEN GIVEN:

- ☐ FEVER SHEET
- ☐ NAUSEA AND VOMITING SHEET
- ☐ SUTURED WOUND SHEET
- ☐ BURN CARE SHEET
- ☐ URINARY TRACT INFECTION SHEET
- ☐ HOME CAST CARE SHEET
- ☐ SPRAIN AND MINOR FRACTURE SHEET
- ☐ CORNEAL ABRASION SHEET
- ☐ PELVIC INFECTION SHEET
- ☐ MALE GONORRHEA SHEET
- ☐ GENITAL HERPES SHEET
- ☐ HEAD INJURY SHEET
- ☐ IMPETIGO SHEET

*Chest pain*

## GENERAL INSTRUCTIONS

- ☐ KEEP DRESSING CLEAN AND DRY
- ☐ KEEP INJURED PART ELEVATED AS MUCH AS POSSIBLE FOR \_\_\_\_\_ DAY(S)
- ☐ NO WEIGHT BEARING
- ☐ RE-WRAP ACE BANDAGE IF TOO LOOSE OR TOO TIGHT
- ☐ ICE (INTERMITTENTLY) TO INJURED AREA FOR \_\_\_\_\_ HOUR(S)
- ☐ CRUTCHES AS NEEDED (THEY ARE SOLD TO YOU)
- ☒ TAKE PRESCRIPTION(S) AS DIRECTED
- ☐ NO DRIVING TODAY
- ☒ REST AT HOME TODAY

☐ YOU HAVE BEEN STARTED ON TETANUS IMMUNIZATION SERIES TODAY. PLEASE COMPLETE THE SERIES WITH YOUR PRIVATE PHYSICIAN:

- 1) 1 MONTH FROM TODAY - ½CC TETANUS TOXOID
  - 2) 2 MONTHS FROM TODAY - ½CC TETANUS TOXOID
- THIS WILL COMPLETE YOUR TETANUS IMMUNIZATION

☐ SIGNS OF POSSIBLE INFECTION TO LOOK FOR:

- REDNESS
- HEAT
- SWELLING
- RED STREAKS

CONTACT YOUR PHYSICIAN IMMEDIATELY IF THESE OCCUR

**ROBERT R. BRINSON, M.D.**

2055 East South Boulevard, Suite ~~706~~ *303*  
Montgomery, Alabama 36116  
(205) 284-1298

*Diplomate, American Board of Internal Medicine  
Diplomate, Subspecialty Board, Gastroenterology  
Fellow, American College of Nutrition*

Gastroenterology  
Clinical Nutrition  
Hyperalimentation

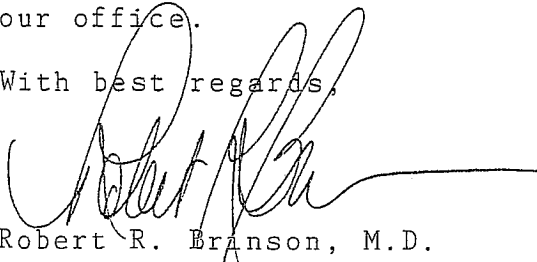
September 10, 1990

To whom it may concern:

John Hooper was seen in our office today. His scheduled appointment was at 3:45pm. He was under our care until 4:45pm at which time he left our office.

If you need additional information, please feel free to contact our office.

With best regards,

A handwritten signature in dark ink, appearing to read 'Robert R. Brinson', followed by a horizontal line extending to the right.

Robert R. Brinson, M.D.



796608-8 MR234741  
 HOOPER, JOHN W  
 DR. BRINSON, ROBERT  
 9/13/90 M 28

(IMPRINT PATIENT'S ADDRESSOGRAPH)

BAPTIST MEDICAL CENTER  
 DISCHARGE INSTRUCTIONS-ENDOSCOPY PATIENTS

DATE: 9/13/90

RETURN TO DR. Brinson OFFICE ON 9/27/90 AT 1:15pm  
 DATE: TIME:

RETURN TO BMC OUTPATIENT SERVICE ON \_\_\_\_\_ AT \_\_\_\_\_ FOR \_\_\_\_\_  
 DATE: TIME: PROCEDURE:

THE FOLLOWING CHECKED INSTRUCTIONS ARE SPECIFIC FOR YOUR PROCEDURE:

1. ☒ Notify your physician if you have any of the following symptoms:
  - A. More than 1 teaspoon of bright red blood in your bowel movement.
  - B. Fever over 100°.
  - C. Severe abdominal pain.
2. ☒ You may experience gas pains and cramps after your examination. If the discomfort does not go away in 6-12 hours, notify your physician.
3. ☒ No alcoholic beverages or tranquilizers for 24 hours.
4. ☒ Rest at home today.
5. ☒ Have a responsible adult accompany you when out of the bed for the next 4 hours or until you do not experience any dizziness.
6. ☒ Do not drive for 24 hours.
7. ☒ Resume normal activities tomorrow.
8. ☒ Resume usual diet in one hour or when your throat is no longer numb.
9. ☒ Follow \_\_\_\_\_ diet as instructed by the dietitian.
10. ☒ No caffeine (coffee, coke, tea).
11. ☒ No aspirin or any medication containing aspirin.
12. ☒ No nicotine.
13. ☒ You may gargle with a saline gargle (1 tsp salt with 2 cups of warm water) or use chloroseptic lozenges for throat discomfort.
14. ☒ You may use a warm, wet compress to your IV site for any redness or discomfort. If redness persists, call your physician.
15. ☒ If your physician removed a polyp or tissue (biopsy) for further examination, he will notify you by phone or in writing as soon as he receives the results. Your physician usually receives this report in 24-48 hours after the tissue is examined by a pathologist.
16. ☒ Take the following medications as ordered by your physician. \_\_\_\_\_
17. ☒ Other specific instructions: \_\_\_\_\_

I acknowledge the receipt and understanding of these instructions. I was informed by

NAME OF PRACTITIONER Brinson

WITNESS C. Meek

SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE X. White

DATE: 9/13/90

DATE: 9/13/90

GEOFFREY W. DAUGHERTY, M.D.  
INTERNAL MEDICINE  
DOCTORS OFFICE BUILDING  
303 SOUTH RIPLEY STREET, SUITE 4600  
MONTGOMERY, AL 36104  
PHONE 205-264-9739

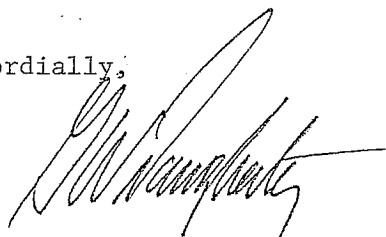
08 June 1990

TO: Supervisor  
City of Montgomery, Garage Dept.

SUBJECT: Medical Statement, John W. Hooper

Mr. Hooper is a 28 year old male who has had difficulties with recurrent subjective fevers, dizziness, abdominal pains, nausea, headaches, joint pains, and weakness since March. He has had repeated blood tests, chest x-ray, endoscopic examinations, CT Scan and consultations with a gastroenterologist and ENT doctors. All of this has shown no definite abnormalities. It is felt that he has an inner ear dysfunction (acute labyrinthitis). Although he never has shown evidence of great distress when seen by me, he reports that his nausea and dizziness prevent him from working frequently. I have been giving him trials with various medications with variable success, but he seems to be improving now. At this time I do not think returning to full duty would jeopardize his health.

Cordially,



Geoffrey W. Daugherty, M. D.

GWD/ja



DRS. ROBINSON, STRONG, YATES & WEBB P.C.  
JAMES T. MC LAUGHLIN, M.D.  
1722 PINE STREET, SUITE 309  
MONTGOMERY, AL 36194-2701  
DEA # AM 2728016  
LIC. # 11460 (AL)

Mr. John Hooper  
Mrs. \_\_\_\_\_  
Ms. \_\_\_\_\_  
has been under my care from 21 Aug 90 to \_\_\_\_\_  
and is able to return to work/school on \_\_\_\_\_  
Remarks Seen in office today for  
medical evaluation  
J.W. Humphreys Phone 264-9739  
Date 21 Aug 90

Lilly Industries, Inc • Carolina, Puerto Rico 00630  
Lilly of Eli Lilly and Company • Indianapolis, Indiana 46285

60-CR-0131-3 PRINTED IN USA 700955-1187100

(205) 262-0342  
NAME John Hooper AGE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ DATE 8/21/90

R. Mr Hooper was seen in  
our office 8/14 with abdominal  
pain and nausea of undetermined  
etiology. He was seen again  
today

## Certificate to return to work or school

Mr. John Hooper  
Mrs. \_\_\_\_\_  
Miss \_\_\_\_\_  
has been under my care from 06 Aug 90 to \_\_\_\_\_  
and is able to return to work/school on 07 Aug 1990  
Remarks Has muscular back and  
abdominal strain from non-work  
related activities  
Dr. J.W. Humphreys, MD Phone 264-9739  
Address 303 S. Ripley Date 06 August 90

Lilly of Eli Lilly and Company • Indianapolis, Indiana 46285

60-CR-0131-0 PRINTED IN U.S.A. 200026-1181100 NOVEMBER, 1981

Refill \_\_\_\_\_ times  
James T. McLaughlin  
PRODUCT SELECTION PERMITTED DISPENSE AS WRITTEN

John Harper  
I have been under my care from seen in office 16 July 90  
and is able to return to work/school on 16 July 90  
seen for medical  
problems  
by W. Humphreys  
Phone 264-9739  
Date 16 July 90

Eli Lilly Industries, Inc. • Carolina, Puerto Rico 00630  
of Eli Lilly and Company • Indianapolis, Indiana 46285  
60-CR-0131-3 PRINTED IN USA 700955-1187100

Mr. John W. Harper  
Mrs. \_\_\_\_\_  
Ms. \_\_\_\_\_  
has been under my care from \_\_\_\_\_ to \_\_\_\_\_  
and is able to return to work/school on 27 April 1990  
Remarks Has Vertigo and Nausea from inner ear  
dysfunction, and seen in office 25 April 90 to  
start new medication  
Dr. W. Humphreys Phone 204-9739  
Address 303 S. Ripley St Date 25 Apr 90

Eli Lilly Industries, Inc. • Carolina, Puerto Rico 00630  
A Subsidiary of Eli Lilly and Company • Indianapolis, Indiana 46285  
60-CR-0131-1 PRINTED IN U.S.A. 500330-38575 FEBRUARY, 1985

DRS. ROBINSON, STRONG, YATES & WEBB, P.C.  
ADULT AND ADOLESCENT PRIMARY CARE  
INTERNAL MEDICINE  
SUITE 309  
1722 PINE STREET  
MONTGOMERY, ALABAMA 36194-2701

PHILLIP R. ROBINSON, M.D.  
PAUL L. STRONG, M.D.  
GLENN A. YATES, M.D.  
JAMES T. McLAUGHLIN, M.D.  
JEANNINE N. SMITHERMAN  
Practice Manager

TELEPHONE  
(205) 262-0342  
NIGHTS 293-8000

TO WHOM IT MAY CONCERN:

John Harper is under my care for illness.  
He/She may return to work/school on 8-15-90.

- ☒ Regular Activity  
( ) Activity as patient tolerated  
( ) Restricted activity until \_\_\_\_\_.

Wm for J. T. McLaughlin M.D.  
Drs. Robinson, Strong, Yates & McLaughlin  
Date 8-14-90

to return to work or school

Case 2 of 3 CSC

Document 24-3

Filed 07/17/2007

Page 59 of 102

A Subsidiary of Eli Lilly and Company, Indianapolis, Indiana 46285

John W. Hooper

for my care from 07 May 90 to 11 May 90

return to work/school on

terminal pain, diagnosis of unknown  
up too ill to work these days.  
04 May 1990 SAW DR MARK  
ANDERSON 09 MAY 90

Phone 284-9739  
Date 11 May 90

es, Inc. • Carolina, Puerto Rico 00630  
Lilly and Company • Indianapolis, Indiana 46285

60-CR-0131-1 PRINTED IN U.S.A. 500330-38575 FEBRUARY, 1985

to return to work or school

John W. Hooper

for my care from to

return to work/school on

pt saw me in the office

Anderson Phone 288-2900  
55 E. 8th Blvd Date 5-9-90  
Montz

es, Inc. • Carolina, Puerto Rico 00630  
Lilly and Company • Indianapolis, Indiana 46285

60-CR-0131-3 PRINTED IN USA 700955-1187100

GEORGE W. DAUGHERTY, M.D.  
Address 1722 Pine St. Suite 903  
Montgomery, AL 36106-4103  
Date

Remarks

and is able to return to work/school on

has been under my care from 4-9-92 to 4-5-92

John Hooper  
Date 11-10-92

Certificate to return to work or school

Certificate to return to work or school

Mr. John W. Hooper  
Mrs.  
Ms.

has been under my care from 03 May 1990 to 04 May 1990

and is able to return to work/school on 05 May 90

Remarks How nervous, abdominal pain

Dr. P. W. Anderson MD Phone 204 9739  
Address Date 04 May 90

Eli Lilly Industries, Inc. • Carolina, Puerto Rico 00630  
A Subsidiary of Eli Lilly and Company • Indianapolis, Indiana 46285

60-CR-0131-1 PRINTED IN U.S.A. 500330-38575 FEBRUARY, 1985

STABLER CLINIC, P.A.

May 1, 1990

John Hooper

has been under my care and will be able

to return to work on May 2, 1990

Dr. Aubrey Stabler

M.D.

Excuse April 30, 1990

John W. Hooper  
has been under my care from 08 Jan 90 to 09 Jan 90  
is able to return to work/school on 10 Jan 90  
marks Severe Influenza

W. Humphreys Phone 264-9739  
Address 303 S. Ripley St. Suite 4000 Date 08 Jan 90

ISTA DISTA PRODUCTS COMPANY, DIVISION OF  
ELI LILLY AND COMPANY • INDIANAPOLIS, INDIANA 46285

60-WJ-0495 PRINTED IN U.S.A. 000774-780:00 JULIE, 1980

John Hooper  
has been under my care for the period  
from: 12-15-86  
to: 12-17-86

No work due to illness  
I confirm that this patient's absence was physician advised.

Signature

Special Instructions:

rtificate to return to work or school

John W. Hooper  
has been under my care from 28 Mar 90 to 30 Mar 90 (I hope)  
is able to return to work/school on 30 Mar 90 (I hope)  
marks Has severe febrile illness with vomiting, etc

W. Humphreys Phone 284-9739  
Address 303 S. RIPLEY ST Date 28 Mar 90

ly Industries, Inc • Carolina, Puerto Rico 00630  
diary of Eli Lilly and Company • Indianapolis, Indiana 46285

60-CR-0131-3 PRINTED IN USA 700955-1187100

## Medically Excused Absence

is is to confirm that  
John W. Hooper

has been under my care  
(Left) unilateral weakness / dizziness  
nuseated from medication  
on 4-17-90 to 4-23-90  
turn to work on 4-24-90

patient's absence was medically advised.  
Dr. Holding Love, & Sawyer  
2173 Normandie Drive

ertificate to return to work or school

John Hooper  
is been under my care from 4/17/90 to 4/18/90  
id is able to return to work/school on 4/18/90  
emarks Was in our office all day

W. Humphreys Phone 281-6327  
Date 4/17/90

Carolina, Puerto Rico 00630  
Company • Indianapolis, Indiana 46285

60-CR-0131-3 PRINTED IN USA 700955-1187100

PER.FORM 30a  
10/22/02

## EMPLOYEE COMMENDATION RECORD

EMPLOYEE: Hooper, John POSITION: Auto Mechanic - Small  
 SUPERVISOR: Albright, Royce DEPT: Gas Engine  
 DATE OF COMMENDATION: 9/11/03 DEPT: Fleet Management

REASON FOR COMMENDATION: (Description of performance or conduct - give specific facts, background information, dates and times)

John is a highly talented small equipment repairman. His efforts keep City equipment, from weedcutters to farm tractors, working properly. He is equally qualified on both gasoline and diesel powered equipment. His efforts on both police department and emergency management projects produced great results that were both on time and at the least possible cost.

Royce W. Albright  
Supervisor

9/11/2003  
Date

My signature indicates that the above matters were discussed with me on  
and that I received a copy of this form.

9/11/2003  
(Month Day Year)

John Hooper  
Employee Signature

ATTACH ADDITIONAL SHEETS AS REQUIRED

PREPARED: 9/15/03

CITY OF MONTGOMERY MERIT INCREASE

PROGRAM: PASREL

FROM: 09/12/03

TO: 09/25/03

PAYABLE DATE: 10/03/03

DEPARTMENT: 48 00 GARAGE

LAST NAME FIRST MI	SSN	POSITION	PAY PERIOD	STP	CURRENT		MERIT DATE	NEW PAY PERIOD	DATE
					HRLY-RT	ANNUAL			
HOOPER	421-90-0925	10	16,649.5	9/25/03	11	17,099.7	9/25/04		
JOHN	5243		1,331.96			1,367.66			
	EW		34,630.96			35,559.06			
	SO9								
	80								

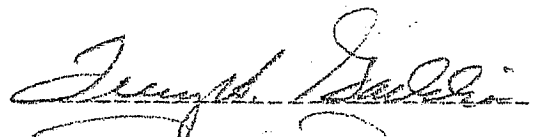
☒ THIS EMPLOYEE IS RECOMMENDED FOR A MERIT INCREASE.

☐ MERIT INCREASE NOT RECOMMENDED AT THIS TIME.

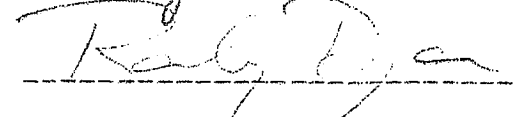
COMMENTS: John Hooper is a highly qualified small engine/equipment technician. His efforts keep the City's small equipment in tip-top mechanical condition. He has earned this increase.

DATE: 15 Sept 2003

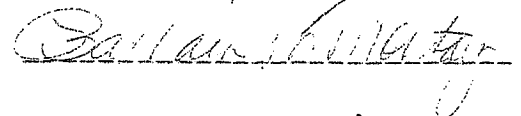
APPROVED: DEPARTMENT HEAD


9/17/03

APPOINTING AUTHORITY


9/17/03

PERSONNEL OFFICER





FORM 50

## REQUEST FOR FAMILY AND MEDICAL LEAVE OF ABSENCE

Employees who have worked for at least 1,250 hours during the 12-month period immediately prior to the request for leave are eligible for leave.

Name: John HooperEmployee Number: 7392Department: Garage Dept.Hire Date: Sept 25 1984

## TYPE OF LEAVE REQUESTED

(check one box)

- ☒ Employee Medical Leave of Absence  
☐ Extension of Employee Medical Leave of Absence  
 Dates of prior approved Medical Leave are:

\_\_\_\_\_to\_\_\_\_\_

- ☐ Family Medical Leave of Absence  
☐ Extension of Family Medical Leave of Absence  
 Dates of prior approved Family Medical Leave are:

\_\_\_\_\_to\_\_\_\_\_

- ☐ Leave to care for newborn or adopted child placed  
 (via state procedures) for foster care

The Leave (or extension) requested will begin on 1/9/04  
 and end on 4/2/04 If the request is for multiple days  
 off for recurring medical treatments of a child, parent, or spouse,  
 or for your own medical treatments, specify dates requested:

## REASON FOR LEAVE

I request a family leave of absence for the following reason:

(Check one box)

- ☒ My personal serious health conditions  
☐ Birth of my child  
☐ Adoption of a child by me  
☐ Placement (by the state) of a child with me for  
 foster care  
☐ Serious health condition of my child  
☐ Serious health condition of my parent  
☐ Serious health condition of my spouse

John Hooper  
 EMPLOYEE SIGNATURE

FORM 51 PER

Leave Certification Requirements

(Check as appropriate)

SECTION I

\_\_\_\_\_ To request leave for the care of a child, parent, or spouse with a serious health condition.

I have attached a certification from the health care provider who is treating my child, parent, or spouse. The certification includes the following:

1. The date on which the condition commenced
2. The probable duration of the condition
3. The appropriate medical facts within the knowledge of the health care provider regarding the condition
4. An estimate of the time needed to care for the individual involved (including any recurring medical treatment)
5. A statement that the condition warrants my participation to provide care.

X SECTION II

\_\_\_\_\_ To request leave for the care of any employee's personal serious health condition. The certification includes the following:

I have attached certification from the health care provider who is treating my own serious health condition. The certification includes the following:

1. The date on which my condition commenced
2. The probable duration of my condition
3. The appropriate medical facts within the knowledge of the health care provider regarding my condition.
4. A statement that am I unable to perform the functions of my position due to my condition

SECTION III

\_\_\_\_\_ Additional certification requirements for intermittent leave or for leave on a reduced leave schedule

In addition to the foregoing certifications from the health care provider involved, I have attached additional information from the health care provider as stipulated below:



FORM 51 PER

       A. Leave for the employee

1. A statement of medical necessity for my intermittent leave or reduced leave schedule and the expected duration of my schedule.
2. A listing of the dates of my planned medical treatment and the duration of the treatment(s).

       B. Leave to care for a son, daughter, spouse or parent who is seriously ill.

1. A statement attesting to the necessity for intermittent leave or reduced leave for me to provide care or to assist in their recovery.
2. An estimate of the expected duration and schedule of my intermittent reduced leave.

I certify by my signature that I have read and understand the organization's certification policy.

Date: 1/9/04 Name (Print) JOHN W. HOOPEREmployee Number: 397 Name (Sign) John Hooper

FORM 55 PER  
(WH-381)

EMPLOYER RESPONSE TO EMPLOYEE  
REQUEST FOR FAMILY OR MEDICAL LEAVE  
(Family and Medical Leave Act of 1993)

(DATE) 5/16/96

TO: John W. Hooper  
(Employee's Name)

FROM: City Shops Department, Terry H. Gaddis, Director  
(Name of appropriate employer representative)

SUBJECT: Request for Family/Medical Leave

On 5/16/96, you notified us of your need to take family/medical leave due to:  
(date)

[ ] the birth of a child, or the placement of a child with you for adoption or foster care; or

☒ a serious health condition that makes you unable to perform the essential functions of your job; or

[ ] a serious health condition affecting your [ ] spouse, [ ] child, [ ] parent, for which you are needed to provide care.

You notified us that you need this leave beginning on 5/16/96 and that you expect leave to continue until on or about unknown date.  
(date) (date)

Except as explained below, you have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period for the reasons listed above. Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or (2) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

This is to inform you that: (check appropriate boxes; explain where indicated)

1. You are ☒ eligible [ ] not eligible for leave under the FMLA.
2. The requested leave ☒ will [ ] will not be counted against your annual FMLA leave entitlement.
3. You ☒ will [ ] will not be required to furnish medical certification of a serious health condition. If required, you must furnish certification by \_\_\_\_\_ (insert date) (must be at least 15 days after you are notified of this requirement) or we may delay the commencement of your leave until the certification is submitted. as required by City Shops Department

4. You may elect to substitute accrued paid leave for unpaid FMLA leave. We ☒ will ☐ will not require that you substitute accrued paid leave for unpaid FMLA leave. If paid leave will be used, the following conditions will apply: (Explain) exhaust accrued leave before LWOP
- 5(a). If you normally pay a portion of the premiums for your health insurance, these payments will continue during the period of FMLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows: (Set forth dates, e.g., the 10th of each month, or pay periods, etc. that specifically cover the agreement with the employee.) contact Risk Mgt. Dept. for arrangements if your check does not cover the employee portion of your premium
- (b). You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work. We ☐ will ☐ will not pay your share of health insurance premiums while you are on leave. See 5(a)
- (c). We ☒ will ☐ will not do the same with other benefits (e.g., life insurance, disability insurance, etc.) while you are on FMLA leave. If we do pay your premiums for other benefits, when you return from leave you ☐ will ☐ will not be expected to reimburse us for the payments made on your behalf.
6. You ☒ will ☐ will not be required to present a fitness-for-duty certificate prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until certification is provided.
- 7(a). You ☐ are ☐ are not a "key employee" as described in §825.218 of the FMLA regulations. If you are a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. n/a
- (b). We ☐ have ☐ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us. (Explain (a) and/or (b) below. See §825.219 of the FMLA regulations.) n/a
8. While on leave, you ☒ will ☐ will not be required to furnish us with periodic reports every \_\_\_\_\_ (indicate interval of periodic reports, as appropriate for the particular leave situation) of your status and intent to return to work (see §825.309 of the FMLA regulations). If the circumstances of your leave change and you are able to return to work earlier than the date indicated on the reverse side of this form, you ☐ will ☐ will not be required to notify us at least two work days prior to the date you intend to report for work.
9. You ☒ will ☐ will not be required to furnish recertification relating to a serious health condition. (Explain below, if necessary), including the interval between certifications as prescribed in §825.308 of the FMLA regulations.)

## MEMORANDUM

TO: Mr. John Hooper

FROM: Mr. Terry H. Gaddis, Director  
City Shops Department

DATE: 15 May 2002

SUBJECT: Assigned Vehicle/Unit(s)

This letter is in compliance with Operating Instruction No. 21 – Care and Maintenance of Department vehicles.

The following Compressor(s), 4800-258, are being assigned to you as primary provider for care and maintenance, effective 15 May 2002. The unit(s) assigned to you will be inspected once a week to determine compliance with the Operating Instructions. Items such as gear shift knobs, turn signal, knobs, tire pressure, wiper blades, upholstery, exterior and interior cleanliness, lights, etc., will be of particular importance, as are the other requirements in the Operating Instruction.

Should, during the course of a follow-up inspection by the Director, Assistant Director or Foreman, it is found that items are missing, broken, not functioning, or in a state of neglect, you will be held peculiarly liable for the cost to repair or replace the items. Therefore, it is in your best interest to carefully inspect the vehicle/unit assigned to you and have any discrepancy repaired.

Additionally, a checklist is available in the Vehicle Administration Office, which will be used during your inspection. This checklist will be turned-in to your Foreman upon completion of your inspection/work. After the Foreman's review, he will forward the checklist to the Assistant Director for his review prior to filing by the clerk. If discrepancies are found during your inspection, the Foreman will forward a copy of the checklist to the Production Controller so a repair order can be initiated to make repairs. The day of the week you make your inspection is an individual choice; however, if you are not the primary operator of the vehicle, coordinate the time and availability with the primary operator. A vacuum cleaner is available outside the paint booth for keeping the interior of the vehicle clean – use it.

The Foreman of your Division will randomly inspect this vehicle to ensure compliance. Our vehicles are very expensive and essential for accomplishing the mission of our Department, so take the pride and responsibility in maintaining your assigned vehicle to the highest standards.

cc: Mr. Royce Albright, Foreman  
Auto Light Equipment Division

M E M O R A N D U M

TO: Mr. John W. Hooper #397

FROM: Mr. Terry H. Gaddis, Director  
City Shops Department

DATE: 22 December 1998

SUBJECT: Assigned Vehicle/Unit(s)

This letter is in compliance with Operating Instruction No. 21--Care and Maintenance of Department vehicles.

The following Vehicle(s), 4800-019, is being assigned to you as primary provider for care and maintenance, effective 22 December 1998. The unit(s) assigned to you will be inspected once a week to determine compliance with the Operating Instructions. Items such as gear shift knobs, turn signal knobs, tire pressure, wiper blades, upholstery, exterior and interior cleanliness, lights, etc., will be of particular importance, as are the other requirements in the Operating Instruction.

Should, during the course of a follow-up inspection by the Director or Assistant Director, it is found that items are missing, broken, not functioning, or in a state of neglect, you will be held peculiarly liable for the cost to repair or replace the items. Therefore, it is in your best interest to carefully inspect the vehicle/unit assigned to you and have any discrepancy repaired.

Additionally, a checklist is available in the Administration Office, which will be used during your inspection. This checklist will be turned-in either to the Director or Assistant Director upon completion of your inspection/work. Day of the week is an individual choice; however, if you are not the primary operator of the vehicle, coordinate the time and availability with the primary operator. A vacuum cleaner is available outside the paint booth for keeping the interior of the vehicle clean --use it.

The Foreman of your Division will also inspect this vehicle to ensure compliance. Our vehicles are very expensive and essential for accomplishing the mission of our Department, so take the pride and responsibility in maintaining your assigned vehicle to the highest standards, and let's set a goal to ensure our City Shops vehicles "OUTSHINE" all other Departments!

cc: Mr. Thessalonia Kendrick, Foreman  
Auto Cycle Division

*Employee file*

## M E M O R A N D U M

TO: Mr. John W. Hooper #397

FROM: Mr. Terry H. Gaddis, Director  
City Shops Department

DATE: 21 March 1994

SUBJECT: Assigned Vehicle/Unit(s)

This letter is in compliance with Operating Instruction No. 21-- Care and Maintenance of Department vehicles.

The following Vehicle, 4800-019 is being assigned to you effective 21 March 1994, for care and maintenance. The unit(s) assigned to you will be inspected once a week to determine compliance with the Operating Instructions. Items such as gear shift knobs, turn signal knobs, tire pressure, wiper blades, upholstery, exterior and interior cleanliness, lights, etc., will be of particular importance, as are the other requirements in the Operating Instruction.

Should during the course of a follow-up inspection by the Director or Assistant Director, it is found that items are missing, broken, not functioning, or in a state of neglect, you will be held peculiarly liable for the cost to repair or replace the items. Therefore, it is in your best interest to carefully inspect the vehicle/unit assigned to you and have any discrepancy repaired.

Additionally, a checklist is available in the Administration Office, which will be used during your inspection. This checklist will be turned-in either to the Director or Assistant Director upon completion of your inspection/work. Day of the week is an individual choice; however, if you are not the primary operator of the vehicle, coordinate the time and availability with the primary operator. A vacuum cleaner is available outside the paint booth for keeping the interior of the vehicle clean -- use it.

The Foreman of your Division will also inspect this vehicle to ensure compliance. Our vehicles are very expensive and essential for accomplishing the mission of our Department, so take the pride and responsibility in maintaining your assigned vehicle to the highest standards, and let's set a goal to ensure our City Shops vehicles "OUTSHINE" all other Departments!

cc: Mr. Robert F. Wade, Foreman  
Auto/Light Truck Division

/mbl



M E M O R A N D U M

TO: Mr. John W. Hooper #397

FROM: Mr. Donald R. Hayes, Director  
Garage Department

DATE: 25 January 1989

SUBJECT: Assigned Vehicle/Unit(s)

This letter is in compliance with Operating Instruction No. 21 - Care and Maintenance of Garage Department vehicles.

The following vehicle/units 4800-019 is being assigned to you effective 25 January 1989 for care and maintenance. The unit assigned to you will be inspected once a week to determine compliance with the Operating Instructions. Items such as gear shift knobs, turn signal knobs, wiper blades, upholstery, interior cleanliness, etc., will be of particular importance, as are the other requirements in the Operating Instruction.

Should during the course of an inspection by the Director or Assistant Director, it is found that items are missing, broken, not functioning, or in a state of neglect, you will be held pecuniarily liable for the cost to repair or replace the items. Therefore, it behooves you to inspect the vehicle/unit assigned to you and have any discrepancy repaired.

In addition, a checklist is available in the Administration Office which shall be complied with at least weekly. This checklist will be turned-in either to the Director or Assistant Director on a weekly basis. Day of the week is an individual choice. A vacuum cleaner is available in the Tool Room for keeping the interior of the vehicle clean. You are strongly encouraged to use it.

The Foreman of your Division is also herewith instructed to inspect this vehicle/unit to ensure compliance. Should repeat discrepancies occur, necessary administrative action shall be taken.

cc: Mr. Robert F. Wade, Foreman



*Personnel Folder*

M E M O R A N D U M

TO: Mr. John W. Hooper #397

FROM: Mr. Donald R. Hayes, Director *D. Hayes*  
Garage Department

DATE: 02 May 1988

SUBJECT: Assigned Vehicle/Unit(s)

This letter is in compliance with Operating Instruction No. 21 - Care and Maintenance of Garage Department vehicles.

The following vehicle/units 4800-019/025 is being assigned to you effective 02 May 1988 for care and maintenance. The unit assigned to you will be inspected once a week to determine compliance with the Operating Instructions. Items such as gear shift knobs, turn signal knobs, wiper blades, upholstery, interior cleanliness, etc., will be of particular importance, as are the other requirements in the Operating Instruction.

Should during the course of an inspection by the Director or Assistant Director, it is found that items are missing, broken, not functioning, or in a state of neglect, you will be held pecuniarily liable for the cost to repair or replace the items. Therefore, it behooves you to inspect the vehicle/unit assigned to you and have any discrepancy repaired.

In addition, a checklist is available in the Administration Office which shall be complied with at least weekly. This checklist will be turned-in either to the Director or Assistant Director on a weekly basis. Day of the week is an individual choice. A vacuum cleaner is available in the Tool Room for keeping the interior of the vehicle clean. You are strongly encouraged to use it.

The Foreman of your Division is also herewith instructed to inspect this vehicle/unit to ensure compliance. Should repeat discrepancies occur, necessary administrative action shall be taken.

cc: Mr. Robert F. Wade, Foreman

Alabama Temporary -- Driver License  
3964706

JOHN WEST HOOPER  
3555 US HWY 31  
LETOHATCHEE AL 36047



Class	Endorse.	Restr.
DM		A
D.O.B.		S.S.N.
09-18-1961		421-90-0925
Sex	Ht.	Wt.
M	5'11	172
		GRN
		BRO
Iss. Date		Exp. Date
05-06-2002		05-01-2006

*[Handwritten signature]*


Class                      Fold Here  
Operator   Motorcycle

Restrictions  
Corrective Lenses

Endorsements

This temporary license is valid until 07/05/2002 . Your new license will be mailed to you . If you do not receive your license within 60 days write: Information Services, PO Box 2471, Montgomery, AL 36102-1471 or telephone 314-242-4100. 043A054

This is to acknowledge that I attended the City of Montgomery's **Harassment in the Workplace** Training class at the Montgomery Civic Center and that I received a copy of Montgomery's Harassment Policy, which I have read and understand.

  
\_\_\_\_\_  
Signature

2-25-02  
Date

## MEMORANDUM

**TO:** Priscilla Williams  
Insurance Clerk

**FROM:** Darlene Parker  
City Shops Department

**DATE:** 9 November 2000

**RE:** Employees' Change of Address for  
Blue Cross/Blue Shield Insurance Records

The following employees had a change of address and their Blue Cross/Blue Shield information needs to be updated to reflect this change so their insurance claims report will go to their correct address. Thank you for your assistance, and if you need additional information, call me at 2509.

<u>Name</u>	<u>Social Security #</u>	<u>New Address</u>
James K. Barnes	420-76-7898	725 Persons Drive Santuck, AL 36092
John Hooper	421-90-0925	3555 U. S. Highway 31 Letohatchee, AL 36047

/dp

# MEMO

To: All City Employees

From: F. Tim McCollum *FTM*  
City Attorney

Subject: Ethics Code Violations

Date: June 10, 1998

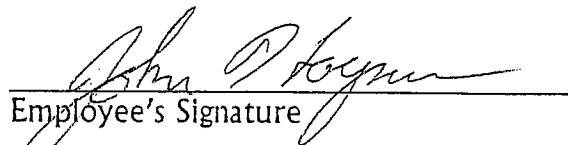
To reiterate - The City of Montgomery's policy towards employee Ethics Code violations is as follows:

"No public official or public employee shall use or cause to be used equipment, facilities, time, materials, human labor, or other public property under his or her discretion or control for the private benefit or business benefit of the public official, public employee, any other person . . . ."§36-25-5(c) Code of Alabama, 1975.

Every employee of the City of Montgomery is a "public employee". Every employee is entrusted by the taxpayers of this city with the responsibility of carrying on business beneficial to the taxpayer. If an employee uses city/taxpayer time, equipment, facilities, materials, his or her work time, someone else's work time, or other public property for personal gain, that employee is guilty of violating the above quoted section. Summed up, the employee cannot use any City equipment to make money or gain a personal benefit. Any employee who engages in the activities described above will be subject to severe disciplinary action in addition to any prosecution by the Alabama Ethics Commission.

FTMcC/mwf

On this the 11 day of June, 1998, I have read the above memorandum and I understand the same.

  
Employee's Signature

Garage Department

CITY AND COUNTY OF MONTGOMERY

PERSONNEL DEPARTMENT

P.O. BOX 1111  
MONTGOMERY, ALABAMA 36101-1111

PERSONNEL BOARD  
MR. JOHN J. BOGG, JR., CHAIRMAN  
MR. C. LAMAR CHAMPION  
MR. EDWARD F. CROWELL

BARBARA M. MONTOYA  
PERSONNEL DIRECTOR  
KAREN B. CASON  
ASSISTANT PERSONNEL DIRECTOR  
TELEPHONE: 205-241-2875  
FAX: 205-241-2219

November 9, 1993


Mayor Emory Folmar  
City Hall  
103 N. Perry Street  
Montgomery, Alabama

Dear Mayor Folmar:

The Personnel Board asked me to advise you that they approved your request to adjust the salary range for Auto Mechanic-Small Gas Engine (5243) from \$21,670/\$27,630 to \$21,670/\$28,625.

If I can be of further assistance, please let me know.

Yours truly,

  
Barbara M. Montoya  
Personnel Director

cc: Mr. Jim Buckalew  
Mr. Don Hayes

FORM 10

Submit in Triplicate

CITY AND COUNTY OF MONTGOMERY  
PERSONNEL DEPARTMENT  
RECOMMENDATION FOR PERSONNEL ACTION

Department/Division City Shops/4800 Date 11 Nov 93Name of Employee John W. Hooper Effective Date 19 Nov 93Classification Auto Mechanic-Small Gas Engine Job Code 5243

Item 2 requires the signature of both department heads.

Items 2, 3, 4, 5, 6, 15 require approval of Personnel Director before action is official. Items 3, 4, 5, 7 must have copy of letter to employee attached. Item 8 should have copy of letter of resignation.

- |   |                                       |
|---|---------------------------------------|
| 1. Transfer within department. .... ( )     | 9. Retirement ..... ( )               |
| 2. Transfer to another department ..... ( ) | 10. Separation by death ..... ( )     |
| 3. Demotion ..... ( )                       | 11. Expiration of Temp. Apt. .... ( ) |
| 4. Layoff. .... ( )                         | 12. Return LWOP ..... ( )             |
| 5. Dismissal. .... ( )                      | 13. Return from Military Lv ..... ( ) |
| 6. Leave without Pay. .... ( )              | 14. Change in Name ..... ( )          |
| 7. Suspension ..... ( )                     | 15. Change in Salary ..... (XX)       |
| 8. Resignation. .... ( )                    | 16. ....                              |

ITEMS AFFECTED BY ACTION

FROM

TO

Department  
(Items 1 & 2)Classification & Salary  
(Items 1, 2, 3)Dates  
(Items 6 & 7)Name  
(Item 14)

Amount	\$27,630	\$28,625
(Item 15)	\$1,062.70 (13.2837)	\$1,100.98 (13.7622)

Other  
(Item 16)

If Action is Resignation or Layoff, is Reemployment Recommended? Yes ( ) No ( )

Funds are available

*Rough Samuel W. ...*  
Disbursing Officer

Date NOV 12 1993

Explanation and remarks (Give reason for any action which is not self-explanatory)

(Signed) 1.

1.

*Emily Tolman*  
Appointing Authority

Date

NOV 15 1993

2.

*Donald R. Hagen*

Date

11 Nov 93

3.

Date

4.

*Barbara M. Montoya*  
Personnel Director

Date

NOV 17 1993



FORM 100

Revised 3/1/84

CITY AND COUNTY OF MONTGOMERY

PERSONNEL DEPARTMENT

SUBMIT IN TRIPLICATE  
WITH FORM 10

## SECTION A

(ITEM 16) If action is re-employment, downgrade (B/W to Wkly), upgrade (Wkly to B/W), or temporary to permanent status, complete Section B instead of Section A.

DEPT/DIV NO. City Shops/4800 EMPLOYEE'S NAME John W. HooperEFFECTIVE DATE Nov / 19 / 93 (MO/DA/YR) SOCIAL SECURITY NO. 421 / 90 / 0925CURRENT CLASSIFICATION & SALARY (ITEMS 1, 2, & 3) JOB CODE 5243 PAY RANGE 310 STEP 7(ITEM 15) NEW HOURLY RATE \$ 13.7622 REVIEW DATE FOR NEXT PAY INCREASE        /        /         
MO DA YR

(ITEM 3, 16 on FORM 10, PROMOTION on FORM 5)

NEW JOB CODE        NEW PAY RANGE        NEW STEP        REVIEW DATE FOR NEXT PAY INCREASE        /        /        MO/DA/YR

IF ACTION IS INVOLVING A PAY OUT ON PAYROLL:

Was employee advanced work time on 4/15/83 B/W or 4/8/83 Wkly Payroll? YES ( ) NO ( )

If YES: How many hours were advanced:        Hrs

After time used on final time sheet, pay remaining leave balance

as follows: ANNUAL LEAVE HOURS:       SICK LEAVE HOURS:        (1/2 ACCRUED)COMPENSATORY HOURS:       TOTAL LEAVE HOURS:       LAST DAY IN PAY STATUS        /        /        (MO/DA/YR)

## SECTION B

SUBMIT IN TRIPLICATE WITH FORMS 3, 5, 8, 9, &amp; 40

DEPT/DIV NO.        VERIFIED SOCIAL SECURITY NO.        /        /       

The following person has been appointed: TEMPORARY ( ) PERMANENT ( )

NAME:        EFFECTIVE DATE:        /        /         
First M.I. Last MO DA YRSTREET ADDRESS:       CITY        STATE        ZIP CODE       RACE        SEX        MARITAL STATUS        NO. DEPENDENTS        BIRTHDATE        /        /         
MO DA YRHourly Rate \$        Job Code        Pay Range        Step        Review Date for next  
Pay Increase        /        /        (MO/DA/YR)

PAID: Wkly ( ) B/W ( ) Will Accrue Leave: Yes ( ) No ( ) Will pay Retirement: Yes ( ) No ( )

Scheduled Hours per Pay Period:        Non-scheduled, pay hours worked only:  
Yes ( ) No ( )

Was Employee previously employed by the City of Montgomery: Yes ( ) No ( )

If Yes:        /        Was paid: Wkly ( ) B/W ( )  
Department Date Terminated

REMARKS:

# **PERSONNEL DEPARTMENT RECOMMENDATION FOR PERSONNEL ACTION**

Department/Division CITY SHOP Date 10/5/2002

Name of Employee JOHN W HOOPER Effective Date 10/11/2002

Social Security # 421-90-0925 Classification AUTO MECHANIC -  
SMALL GAS ENG Job Code 5243

Item 2 requires the signature of both department heads.

Items 2, 3, 4, 5, 6, 15 require approval of Personnel Director before action is official. Items 3, 4, 5, 7 must have copy of letter to employee attached. Item 8 should have copy of letter of resignation.

- |   |  |
|---|--|
| 1. Transfer within department ..... ( )     | 9. Retirement ..... ( )                          |
| 2. Transfer to another department ..... ( ) | 10. Separation by death ..... ( )                |
| 3. Demotion ..... ( )                       | 11. Expiration by Temporary Appointment..... ( ) |
| 4. Layoff ..... ( )                         | 12. Return Leave Without Pay..... ( )            |
| 5. Dismissal ..... ( )                      | 13. Return from Military Leave..... ( )          |
| 6. Leave without pay ..... ( )              | 14. Change of Name ..... ( )                     |
| 7. Suspension ..... ( )                     | 15. Change in Salary ..... ( x )                 |
| 8. Resignation ..... ( )                    | 16. Change in Title ..... ( )                    |

ITEMS AFFECTED BY ACTION	FROM	TO																					
Department (Items 1 & 2)																							
Classification & Salary (Items 1, 2, 3)																							
Dates (Items 6 & 7)																							
Name (Item 14)																							
Amount (Item 15)	<table border="1"> <tr> <td>Pos/Grade/Step</td> <td>5243</td> <td>310</td> <td>8</td> </tr> <tr> <td>Hrly/BW</td> <td>16.1420</td> <td>1,291.36</td> <td></td> </tr> <tr> <td>Annual</td> <td>33,575.36</td> <td></td> <td></td> </tr> </table>	Pos/Grade/Step	5243	310	8	Hrly/BW	16.1420	1,291.36		Annual	33,575.36			<table border="1"> <tr> <td>5243</td> <td>S09</td> <td>10</td> </tr> <tr> <td>16.6495</td> <td>1,331.96</td> <td></td> </tr> <tr> <td>34,631.00</td> <td></td> <td></td> </tr> </table>	5243	S09	10	16.6495	1,331.96		34,631.00		
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5243	S09	10																					
16.6495	1,331.96																						
34,631.00																							
Other (Item 16)																							

Funds are available E. Lloyd Fouch Date OCT - 9 2002  
Disbursing Officer

## **Explanation and remarks (Give reason for any action which is not self-explanatory)**

Employee warrants 1 step merit increase per rule 4 of new Pay Plan.

reinstate Merit date to 7-25-84

(Signed) 1. [Signature] Date OCT - 9 2002  
Appointing Authority

2. [Signature] Date OCT 5, 2002

3. \_\_\_\_\_ Date \_\_\_\_\_

4. [Signature] Date OCT 16 2002  
Personnel Director

CITY OF MONTGOMERY

GARAGE DEPARTMENT

Payroll Deduction Authorization

TOOL CONTRACT

V-016

I, John W. Hooper,  
(Name - please type)  
S. S. #421-90-0925, do hereby  
authorize my employer to deduct \$ 20.00  
(minimum - \$20.00)  
from my pay until a total of \$ 2,614.90  
is attained. Beginning this date: May 16 1985.

SIGNED :

John W. Hooper

CITY OF MONTGOMERY

GARAGE DEPARTMENT

Payroll Deduction Authorization

TOOL CONTRACT

V-016

I, John W. Hooper,

(Name - please type)

S. S. # 421-90-0925, do hereby

authorize my employer to deduct \$ 20.00  
(minimum - \$20.00)

from my pay until a total of \$ 2,773.40

is attained. Beginning this date: February 7 1985.

SIGNED :

John Hooper

FORM 100

## CITY PAYROLL DEPARTMENT

SUBMIT IN TRIPLICATE

## Section A To be completed for items 1, 2, 3, 15 &amp; 16 on Form 10 and Promotion on Form 5

Dept./Div. Number 4800/711Employee's Name JOHN W HOOPEREffective Date 10/11/2002Social Security Number: 421-90-0925

MO. DA. YR.

CURRENT CLASSIFICATION &amp; SALARY

52433108

JOB CODE

PAY RANGE

STEP

## NEW CLASSIFICATION &amp; SALARY INFORMATION

NEW PAYROLL/DEPT#

NEW JOB CODE 5243NEW PAY RANGE S09NEW STEP 10IF APPLICABLE  
REVIEW DATE  
FOR NEXT  
INCREASE9/10/05  
(MO/DA/YR)

ITEM 15 NEW HOURLY RATE:

16.6495

WKLY / BW

1,331.96

SCH. HOURS

IF ACTION INVOLVES A PAY OUT ON PAYROLL, WAS EMPLOYEE ADVANCED WORK TIME ON BI-WKLY 4/15/83  
WEEKLY PAYROLL 4/8/83 OR BI-WEEKLY/WEEKLY 1985?

YES/NO

IF YES: HOW MANY HOURS WERE ADVANCED:

(1983)

HOURS

(1985)

HOURS

TOTAL

0.0

HOURS

AFTER TIME USED ON FINAL TIME SHEET, PAY REMAINING LEAVE BALANCES AS FOLLOWS:

ANNUAL LEAVE HOURS:

SICK LEAVE HOURS:

(1/2 Accrued)

COMPENSATORY HOURS

PERSONAL LEAVE HOURS:

TOTAL LEAVE HOURS:

0.0

LAST DAY IN PAY STATUS:

## Section B To be completed with Forms 3,5,8,9 &amp; 40 or Re-employment on Form 10

DEPARTMENT/DIVISION NUMBER:

VERIFIED SOCIAL SECURITY NUMBER

THE FOLLOWING PERSON HAS BEEN APPOINTED TEMPORARY:

PERMANENT:

NAME:

FIRST:

MI

LAST

EFFECTIVE DATE:

(MO/DA/YR)

STREET ADDRESS

CITY

STATE

ZIP

PHONE NUMBER

RACE

SEX

MARITAL  
STATUSNO. OF  
DEPENDENTS

BIRTHDAY

HOURLY RATE

JOB CODE

PAY RANGE

STEP

REVIEW DATE

PAID:

WEEKLY

BI-WEEKLY

WILL ACCRUE LEAVE:

YES

NO

WILL PAY RETIREMENT:

YES

NO

SCHEDULED HOURS PER PAY PERIOD:

NON-SCHEDULED, PAID HOURS WORKED ONLY:

WAS EMPLOYEE PREVIOUSLY EMPLOYED BY THE CITY OF MONTGOMERY?

YES/NO

PAID WKLY OR BW

IF YES:

DEPT #

TERM. DATE

PREVIOUS SERVICE

MONTHS DAYS YEARS

REMARKS:

REVISED 5-03-02 PYR/RW

DATE: 20 Sep 1996

TO: Mr. John Hooper #397

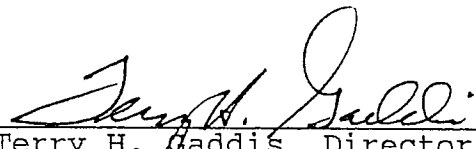
SUBJECT: Assigned Duty Hours

1. Effective 20 Sept. 1996, you are hereby assigned the following duty hours. You are to report to work no later than 0630 hours, Monday through Friday. You will have a ONE HALF HOUR LUNCH PERIOD, which is to be coordinated with your supervisor. Your duty period ends at 1500 hours.

2. Holidays and weekend overtime may have different working hours. Weekend or holiday work schedules will be posted near the time clock reflecting the individuals scheduled for work, plus their work hours.

3. Your assigned duties are: AUTO MECHANIC - SMALL GAS ENGINE. From time to time your duty assignment may be changed due to Departmental requirements. The Class Specification as outlined in the City and County of Montgomery Personnel Rules and Regulations, Rule V states, in part, the following....."They are intended to indicate the kinds of positions that are allocated to the several classes, as determined by their duties and responsibilities, and shall not be construed as declaring to any extent, or in any way what the duties or responsibilities of any position shall be, or as limiting or in any way modifying the power of any appointing authority or administrative officer to assign, direct and control the work of employees under supervision."

4. Mr. KENDRICK, your supervisor, will outline your specific duties.

  
Terry H. Gaddis, Director  
City Shops Department

DATE: 21 March 1991

TO: Mr. John W. Hooper

#397

*Personnel File*

SUBJECT: Assigned Duty Hours

1. Effective 25 March 1991 you are hereby assigned the following duty hours. You are to report to work no later than 0630 hours, Monday through Friday. You will have a Thirty (30) minute lunch period which will be coordinated with your supervisor. Your duty period ends at 1500 hours.
2. Holidays and weekend overtime may have different working hours. Weekend and holiday work schedules will be posted near the time clock reflecting the individuals scheduled for work plus their work hours.
3. Your assigned duties are Automotive Mechanic --- Automotive/Light Truck Division From time to time your duty assignment may be changed due to departmental requirements. The Class Specification as outlined in the City and County of Montgomery Personnel Rules and Regulations, Rule V states, in part, the following . . . .  
"They are intended to indicate the kind of positions that are allocated to the several classes, as determined by their duties and responsibilities, and shall not be construed as declaring to any extent, or in any way what the duties or responsibilities of any position shall be, or as limiting or in any way modifying the power of any appointing authority or administrative officer to assign, direct and control the work of employees under supervision."
4. Mr. Robert F. Wade, your supervisor, will outline your specific duties.

*Donald R. Hayes*

---

Donald R. Hayes, Director  
City Shops Department



Date 10 September 84To: Mr. John W. Hooper #397*Personnel File*

Subject: Assigned Duty Hours

1. Effective 25 September 1984, you are hereby assigned the following duty hours. You are to report to work no later than 7:00 a.m. Monday through Friday. You will have a Hour Day Day 30-minute lunch/dinner period which will be coordinated with your supervisor. Your duty periods ends at 3:30 p.m.
2. Holidays and weekend overtime may have different working hours. Weekend and holiday work schedules will be posted near the time clock reflecting the individuals scheduled for work plus their work hours.
3. Your assigned duties are Automotive Mechanic/Auto - Light Truck Division. From time to time your duty assignment may be changed due to departmental requirements. The Class Specification as outlined in the City and County of Montgomery Personnel Rules and Regulations, Rule V states, in part, the following . . . . "They are intended to indicate the kind of positions that are allocated to the several classes, as determined by their duties and responsibilities, and shall not be construed as declaring to any extent, or in any way what the duties or responsibilities of any position shall be, or as limiting or in any way modifying the power of any appointing authority or administrative officer to assign, direct and control the work of employees under his supervision."
4. Mr. William C. Coker, your supervisor, will outline your specific duties.

*Donald R. Hayes*Donald R. Hayes, Director  
Garage Department

FORM 5

Submit in Triplicate

CITY AND COUNTY OF MONTGOMERY  
PERSONNEL DEPARTMENT  
PERSONNEL REQUISITION, CERTIFICATION, AND APPOINTMENT

## REQUISITION

To: Personnel Department

Date August 27, 1984

Please certify the names of persons eligible for the following position:

Title	Compensation	Temporary	Permanent
Auto Mechanic (Small Gas Engine)	\$13,879 533.80 6.6725		

(X) Replacement of Dennis K. Howson

( ) New Position

Date \_\_\_\_\_ Signature \_\_\_\_\_  
Appointing Authority

Funds are available \_\_\_\_\_ Date SEP 6 1984  
Disbursing Officer

## CERTIFICATION TO:

## GARAGE &amp; SHOPS

In response to your request, the names of the following persons who are eligible for appointment are hereby certified. In making appointments, it is advisable, though not essential, that you interview all eligible persons certified.

Name	Address	Phone	Age	Grade
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## APPOINTMENT

TO: Personnel Department

From Garage  
Department

From the certification above, the following person has been appointed:

Name	Effective Date	Temporary	Permanent
John W. Hooper	25 September 84		XX

Appointed by Emory Johnson Date SEP 07 1984  
Appointing Authority

Donald R. Hayer Date 6 September 84  
Department Head

Approved by Salvador M. Montoya Date 9/7/84  
Personnel Director

(ITEM 16) IF ACTION IS RE-EMPLOYMENT, DOWNGRADE (B/W TO WKLY), UPGRADE (WKLY TO B/W), OR TEMPORARY TO PERMANENT STATUS, COMPLETE SECTION B INSTEAD OF SECTION A.

DEPARTMENT/DIVISION NUMBER \_\_\_\_\_ EMPLOYEES' NAME \_\_\_\_\_

EFFECTIVE DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ (MO./DA./YR.) SOCIAL SECURITY NUMBER \_\_\_\_/\_\_\_\_/\_\_\_\_

CURRENT CLASSIFICATION & SALARY (ITEMS 1, 2, & 3) JOB CODE \_\_\_\_\_ PAY RANGE \_\_\_\_\_ STEP \_\_\_\_\_

ITEM 15) NEW HOURLY RATE \$ \_\_\_\_ REVIEW DATE FOR NEXT PAY INCREASE \_\_\_\_/\_\_\_\_/\_\_\_\_ (MO./DA./YR.)

ITEM 3, 16 on FORM 10, PROMOTION on FORM 5)

NEW JOB CODE \_\_\_\_\_ NEW PAY RANGE \_\_\_\_\_ NEW STEP \_\_\_\_\_ REVIEW DATE FOR NEXT PAY INCREASE \_\_\_\_/\_\_\_\_/\_\_\_\_  
MO. DA. YR.

IF ACTION IS INVOLVING A PAY OUT ON PAYROLL:

AS EMPLOYEE ADVANCED WORK TIME ON 4/15/83 B/W OR 4/8/83 WKLY PAYROLL? YES ( ) NO ( )

YES: HOW MANY HOURS WERE ADVANCED: \_\_\_\_ HRS. AFTER TIME USED ON FINAL TIME SHEET, PAY REMAINING LEAVE BALANCES AS FOLLOWS: ANNUAL LEAVE HOURS: \_\_\_\_\_

SICK LEAVE HOURS: \_\_\_\_\_ (1/2 ACCRUED)

COMPENSATORY HOURS: \_\_\_\_\_

TOTAL LEAVE HOURS: \_\_\_\_\_

1ST DAY IN PAY STATUS \_\_\_\_/\_\_\_\_/\_\_\_\_ (MO./DA./YR.)

# SECTION B

SUBMIT IN TRIPLICATE WITH FORMS 3, 5, 8, 9, & 40

DEPARTMENT/DIVISION NUMBER 4800 VERIFIED SOCIAL SECURITY NUMBER 421 / 90 / 0925

THE FOLLOWING PERSON HAS BEEN APPOINTED: TEMPORARY ( ) PERMANENT (XX)

NAME: John W. Hooper EFFECTIVE DATE 9 / 25 / 84  
FIRST INITIAL LAST MO. DA. YR.  
HOME ADDRESS Rt. 1, Box 122 CITY Fort Deposit STATE AL ZIP

RACE W SEX M MARITAL STATUS M NO. DEPENDENTS BIRTHDATE 9 / 18 / 61 (MO./DA./YR.)

HOURLY RATE \$ 6.6725 JOB CODE 5243 PAY RANGE 0280 STEP 1 REVIEW DATE FOR NEXT PAY INCREASE 9 / 24 / 85  
MO. DA. YR.

WEEKLY ( ) B/W (X) WILL ACCRUE LEAVE: YES (X) NO ( ) WILL PAY RETIREMENT: YES (X) NO ( )

SCHEDULED HOURS PER PAY PERIOD: 80.00 NON-SCHEDULED, PAY HOURS WORKED ONLY: YES ( ) NO (X)

IS EMPLOYEE PREVIOUSLY EMPLOYED BY THE CITY OF MONTGOMERY: YES ( ) NO (X)

YES: / WAS PAID: WKLY ( ) B/W ( )  
DEPARTMENT DATE TERMINATED

REMARKS:

APPLICATION FOR EMPLOYMENT  
CITY AND COUNTY OF MONTGOMERY  
"An Equal Opportunity Employer"  
PERSONNEL DEPARTMENT  
City Hall  
Montgomery, Alabama 36192

	Accepted	Rejected
Cit.		
Ed.		
Exp.		
Res.		
Other		

Title of Position:

AUTO MECHANIC (SMALL GAS ENGINES)

INSTRUCTIONS:  
ALL BLANKS MUST BE  
FILLED IN COMPLETELY

Name: (Type or print name)

Mr. John West Hooper Race W Age 22

Miss Rt 1 Box 122 Ft. Deposit AL 36032 Tel. No. 227-5615

How long have you lived in Alabama immediately prior to date of application 22

Are you a U.S. citizen? Yes

Date of Birth 9-18-61 Place of Birth Montgomery AL

PERSONAL DATA: Height 6 ft. 0 in. Weight 185 lbs. What is the condition of your health? Good

Marital Status: Single ☐ Married ☒ Divorced ☐ Widowed ☐ Number of dependents under 18. 0

Do you have any physical handicaps? No. If so, attach a description to this application. Do you object to having your present employer questioned about your work? No. Have you ever been discharged or forced to resign from a position? No. If so, attach a complete explanation to this application. Have you ever been convicted of any law violation other than a minor traffic violation? No. If so, give name and location of court, date, nature of charge and disposition.

SOCIAL SECURITY NO. 421-90-0925

EDUCATION	Circle Highest Grade you Completed	Date Completed
Grammar and High School	1 2 3 4 5 6 7 8 9 10 11 12 <u>12</u>	<u>1980</u>
College or University (name of schools)	1 2 3 4 5 6 7 Degrees	
	Major	
Business, Trade or Correspondence School		
	Courses Studied	
List your professional certificate or license		

List three reliable persons, not relatives or employers, who know you well enough to give information about you:

	Address	Occupation
<u>Bill Skinner</u>	<u>Rt 1 Greenville (382-2162)</u>	<u>Quality Inspector</u>
<u>Gary McGough</u>	<u>Montgomery City Garage</u>	<u>Welder</u>
<u>Johnny Andrews</u>	<u>Greenville - Andrews scrub station</u>	<u>1cc/19.2's &amp; owner</u>

## WORK HISTORY

Beginning with your PRESENT or most recent employment, list in REVERSE ORDER periods of employment. Each time you changed jobs or your title changed should be listed as a separate period. Give complete information, especially about the kind of work you did. (Use extra sheet if necessary). Applicant must be specific and accurate in stating their experience and training for this position.

## EMPLOYMENT RECORD: List all employment

Employment Dates	Occupation and Description of Duties	Employer's Name and Address	Salary Received	Reason For Leaving
ROM 79	Auto Mechanics	Bill Norman Pontiac	\$100 <sup>00</sup>	out of business
80	work on small motors and	Greenville		
DETAL MOS	Cars			
ROM 80	Auto Mechanics	Goodyear tire & rubber	\$135 <sup>00</sup>	out of business
81	work on small Motors and	Greenville		
DETAL MOS	Cars - tire changer, front end, tune up			
ROM 76	projectionist	K. H. 1-kester	\$75 <sup>00</sup>	out of business
78	run projectors			
DETAL MOS				
ROM 80	Part time small motors	Logan small motors	between \$50.00 - \$100.00	
present	Mechanics	Ft. Deposit		
DETAL MOS				
81	Computer operator	Boss M.C.	\$144 <sup>00</sup>	
present	running - Hewlett Packard			
DETAL MOS	Computer Center			
ROM 82	Stock boy part time	Howards Brothers	\$100 <sup>00</sup>	<del>out of business</del>
83	Aspy toys & bikes etc.			no more work
DETAL MOS	3			
ROM 68	work on Honda Motorcycles	work on the side		
present	and other Brands &	20 hr. weekly		
DETAL MOS	chainsaws & lawnmowers	mostly work on Hondas & Suzukis		
ROM	Over haul & tune ups	and lawn mowers & Boat motors		
DETAL MOS				

6. Show other experience by using additional sheets.

I hereby certify that all statements made hereon and attached hereto are true and correct to the best of my knowledge. Any false statement may be cause for denying me the right to examination or employment.

Date 3/21/84

Signature

John Hooper

ITEM 16) IF ACTION IS RE-EMPLOYMENT, DOWNGRADE (B/W TO WKLY), UPGRADE (WKLY TO B/W), OR TEMPORARY TO PERMANENT STATUS, COMPLETE SECTION B INSTEAD OF SECTION A.

DEPARTMENT/DIVISION NUMBER \_\_\_\_\_ EMPLOYEES' NAME \_\_\_\_\_

EFFECTIVE DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ (MO./DA./YR.) SOCIAL SECURITY NUMBER \_\_\_\_/\_\_\_\_/\_\_\_\_

CURRENT CLASSIFICATION & SALARY (ITEMS 1, 2, & 3) JOB CODE \_\_\_\_\_ PAY RANGE \_\_\_\_\_ STEP \_\_\_\_\_

ITEM 15) NEW HOURLY RATE \$ \_\_\_\_\_ REVIEW DATE FOR NEXT PAY INCREASE \_\_\_\_/\_\_\_\_/\_\_\_\_ (MO./DA./YR.)

ITEM 3, 16 on FORM 10, PROMOTION on FORM 5)

NEW JOB CODE \_\_\_\_\_ NEW PAY RANGE \_\_\_\_\_ NEW STEP \_\_\_\_\_ REVIEW DATE FOR NEXT PAY INCREASE \_\_\_\_/\_\_\_\_/\_\_\_\_  
MO. DA. YR.

ACTION IS INVOLVING A PAY OUT ON PAYROLL:

IS EMPLOYEE ADVANCED WORK TIME ON 4/15/83 B/W OR 4/8/83 WKLY PAYROLL? YES ( ) NO ( )

YES: HOW MANY HOURS WERE ADVANCED: \_\_\_\_\_ HRS. AFTER TIME USED ON FINAL TIME SHEET, PAY REMAINING LEAVE BALANCES

AS FOLLOWS: ANNUAL LEAVE HOURS: \_\_\_\_\_

SICK LEAVE HOURS: \_\_\_\_\_ (1/4 ACCRUED)

COMPENSATORY HOURS: \_\_\_\_\_

TOTAL LEAVE HOURS: \_\_\_\_\_

FIRST DAY IN PAY STATUS \_\_\_\_/\_\_\_\_/\_\_\_\_ (MO./DA./YR.)

# SECTION B

SUBMIT IN TRIPLICATE WITH FORMS 3, 5, 8, 9, & 40

DEPARTMENT/DIVISION NUMBER 4800 VERIFIED SOCIAL SECURITY NUMBER 421 / 90 / 0925

IS FOLLOWING PERSON HAS BEEN APPOINTED: TEMPORARY ( ) PERMANENT (XX)

NAME: John W. Hooper EFFECTIVE DATE 9 / 25 / 84  
FIRST INITIAL LAST MO. DA. YR.

STREET ADDRESS Rt. 1, Box 122 CITY Fort Deposit STATE AL ZIP \_\_\_\_\_

RACE W SEX M MARITAL STATUS M NO. DEPENDENTS \_\_\_\_\_ BIRTHDATE 9 / 18 / 61 (MO./DA./YR.)

HOURLY RATE \$ 6.6725 JOB CODE 5243 PAY RANGE 0280 STEP 1 REVIEW DATE FOR NEXT PAY INCREASE 9 / 24 / 85  
MO. DA. YR.

WID: WKLY ( ) B/W (X) WILL ACCRUE LEAVE: YES (X) NO ( ) WILL PAY RETIREMENT: YES (X) NO ( )

SCHEDULED HOURS PER PAY PERIOD: 80.00 NON-SCHEDULED, PAY HOURS WORKED ONLY: YES ( ) NO (X)

IS EMPLOYEE PREVIOUSLY EMPLOYED BY THE CITY OF MONTGOMERY: YES ( ) NO (X)

YES: \_\_\_\_\_ WAS PAID: WKLY ( ) B/W ( )  
DEPARTMENT DATE TERMINATED

REMARKS:



NEW EMPLOYEE BRIEFING OUTLINE

The Employee Briefing Outline shall be completed for each new employee on his/her first day at work. In the space provided before each subject area, enter the briefer's man number when the action has been completed.

<u>399</u> JOB DESCRIPTION REVIEWED	<u>399</u> PROBATION PERIOD
<u>399</u> HOURS, WORK WEEK, WEEKENDS	<u>399</u> TERMINATION
<u>399</u> OVERTIME, WHEN, PAY, COMP	<u>399</u> ATTENDANCE, PUNCTUALITY
<u>321</u> JOB EVALUATION - "THE SUPERVISOR"	<u>399</u> DRESS CODE
<u>399</u> PAY PERIODS, FIRST PAY DAY	<u>399</u> ORGANIZATIONAL STRUCTURE
<u>399</u> MERIT SYSTEM - PAY STEPS	<u>399</u> AUTO PARKING
<u>399</u> VACATIONS - HOLIDAYS	<u>321</u> LUNCH AREAS
<u>399</u> ANNUAL LEAVE - COMP TIME	<u>321</u> EMPLOYEE FUEL CARD - USE
<u>399</u> EMERGENCY LEAVE	<u>399</u> GAMBLING, DRUGS, WEAPONS
<u>399</u> CITY BENEFITS	<u>399</u> TELEPHONE CALLS, IN/OUT
<u>321</u> REST PERIODS	<u>399</u> USE OF CITY VEHICLE
<u>399</u> OPERATING INSTRUCTIONS	<u>321</u> INTRODUCTION TO CO-WORKERS
<u>399</u> DISCIPLINE	<u>321</u> TOUR OF FACILITY

I understand the above are general Garage Department guide lines and may be changed as business necessity requires. The above do not constitute a written contract and I understand my employment, and qualification thereof, must satisfy the City and County of Montgomery Personnel Board Rules and Regulations.

I acknowledge that the above subjects have been discussed.

John W. Hooper 9-25-84  
Employee's signature / Date  
JOHN W. HOOPER # 397

Donald R. Hayes 25 Sep 84  
Department Head / Date

William C. Coker 9-25-84  
Supervisor's signature / Date



CHECKLIST FOR PROCESSING NEW EMPLOYEE

- ✓ CONFIDENTIAL EMPLOYEE HISTORY FOLDER
- ✓ COPY OF JOB DESCRIPTION
- ✓ ASSIGNED DUTY HOURS FORM
- ✓ ASSIGN TIME CARD (USE RADIO CALL/TOOL CHIT NUMBER)
- ✓ (1) LOCATOR CARD\*
- ✓ 2 / 3 x 5 CARDS (1 FOR ALPHABETICAL CARD FILE, ~~1 FOR MERIT INCREASE FILE~~)
- N/A (1) W-4 FEDERAL TAX FORM\*
- N/A (1) A-1 STATE TAX FORM\*
- N/A (1) TRAVELER'S SUPPLEMENTAL INSURANCE CARD (YELLOW)
- N/A (1) RETIREMENT MEMBERSHIP FORM
- ✓ (1) PASS TO CITY LOT (NIGHT-DAY PHONE NUMBER)
- N/A (1) BLUE CROSS HOSPITALIZATION APPLICATION CARD (WHITE)
- N/A (1) EMPLOYEE ACTIVITY CARD (BLUE)
- ✓ (1) BLUE CROSS BENEFITS BOOKLET
- DRIVERS LICENSE NUMBER 39601101 EXPIRATION DATE 5-1-84
- ✓ EMPLOYEE READS OPERATING INSTRUCTIONS AND SIGN OI CARD
- CLOTHING SIZES: PANTS: W \_\_\_\_\_ L \_\_\_\_\_; SHIRTS: \_\_\_\_\_
- ✓ PERSONNEL HISTORY FORM
- N/A PAYROLL COMPUTER NEW HIRE INPUT FORMS
- N/A PAYROLL COMPUTER INSURANCE HISTORY FORM
- ADMINISTRATIVE OFFICE WILL CONTACT SAFETY SUPERVISOR AT EXT. 368 FOR EMPLOYEE TO BE SCHEDULED FOR CITY DRIVER'S LICENSE
- ✓ EMPLOYEE IDENTIFICATION CARD FOR FUEL SYSTEM

Hooper, John W.  
NAME

Auto Mechanic  
POSITION

9-25-84  
DATE PROCESSED

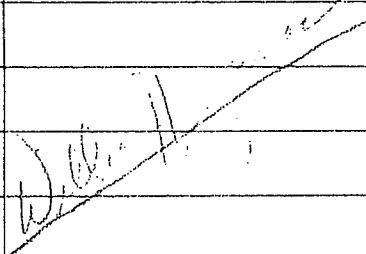
\*Make 1 photocopy of each and place in Personnel Folder

3

## TRAINING REPORT

NAME OF PURCHASER Garage/Public Works Facility ORDER DATE 10-19-84  
 BUSINESS ADDRESS 934 North Ripley Street  
 CITY Montgomery COUNTY Montgomery STATE AL ZIP 36106  
 P.O. NUMBER \_\_\_\_\_ DATE SHIPPED 10-27-84

TO OPERATIONS MANAGER: Please assign the proper mechanics to the Sun Representative for familiarization training. When this has been completed, on each model, your signature is required, to confirm that these men have received this training.

MODEL	SERIAL NUMBER	DESCRIPTION	SIGNATURE
VAT-40	0790	VOLT AMPERAGE TESTER	
PTS-40	2378	PORTABLE ST. 9-11	
VAT-40	0864	VOLT AMPERAGE TESTER	
PTS-40	2377	PORTABLE ST. 9-11	

THE FOLLOWING MEN HAVE BEEN TRAINED:

MODELS TRAINED ON: VAT 40

DEPARTMENT: \_\_\_\_\_

W. L. Lee, R. B. Lee, Ray Lee, J. Lee, C. Lee  
A. T. Lee, Daniel C. Lee

TRAINING

DATES 16 NOV 84

TOTAL

TRAINING TIME 1 HOUR

COMMENTS

ON TRAINING: \_\_\_\_\_

SUN SALES REPRESENTATIVE: FOR PROPER CREDIT, COMPLETED AND RETURN NO. 1 NO. 2 COPIES PROMPTLY TO YOUR REGIONAL SALES MANAGER

SUN

REPRESENTATIVE WILLIAM L. LEE

NO.

1 6 5 3 9

REGIONAL  
NUMBER

4 0 1 3

ZONE  
NUMBER

761

REGIONAL

SALES MANAGER C. Lee

SEND NO. 1 COPY TO SALES COMMISSIONS DEPT.

## FINAL COPY DISTRIBUTION

NO. 1. TO SALES COMMISSION DEPT.

NO. 4. TO REG. SALESMGR. — "HOLD" COPY

NO. 2. TO REG. SALES MGR.

NO. 5. SALES REPRESENTATIVES COPY

NO. 3. TO CUSTOMER'S OPERATIONS MGR.

CUSTOMER'S OPERATIONS MGR.

DATA FOR PAY ROLL

1. NAME: Hooper, John A  
 2. SOCIAL SECURITY NO. 421 25 62 20  
 3. HOME PHONE NO. 0 - - - - -  
 4. SPOUSE'S NAME: Dana Hooper  
 5. FATHER'S NAME: John Hooper  
 6. MOTHER'S MAIDEN NAME: Opal Blend  
 7. WORK ASSIGNMENT: 1000 DATE: 04-24-04  
 8. DIVISION: ALL  
 9. SHIFT: 1500 - 1530  
 10. DATE OF LAST PHYSICAL         
 11. HEIGHT: FEET 6 INCHES 2 WEIGHT: POUNDS 190  
 12. BLOOD TYPE    

## IN CASE OF EMERGENCY, NOTIFY:

1. NAME Hilda McGoogh RELATIONSHIP 0  
 PHONE # 227 - 8615  
 OTHER #         
 2. NAME Opal Hooper RELATIONSHIP 1  
 PHONE # 842 - 3364  
 OTHER #       

## RELATIONSHIP CODES:

CODE	DESCRIPTION
A	AUNT
B	BROTHER
C	CHILD
F	FATHER
G	GUARDIAN
H	HUSBAND
M	MOTHER
O	OTHER
S	SISTER
U	UNCLE
W	WIFE

THIS CONTRACT VOIDS AND SUPERCEDES PREVIOUS CONTRACT DATED  
FEBRUARY 7, 1985.

STATE OF ALABAMA )

COUNTY OF MONTGOMERY )

AGREEMENT

THIS AGREEMENT made this the 16th day of May,  
1985, John W. Hooper, an employee of the  
City of Montgomery, Department of Garage and Shops (hereinafter  
referred to as "purchaser") and the City of Montgomery,  
Alabama, a municipal corporation (hereinafter referred to as  
"City") witnesseth:

WHEREAS, the City is desirous that its employees in the  
Department of Garage and Shops purchase and retain ownership  
of mechanics' tool sets so that said tools can and will be  
used by such employees in carrying out their job with the  
City; and

WHEREAS, the purchaser is a mechanic employed by the  
City of Montgomery, Department of Garage and Shops and is  
desirous of purchasing from the City of Montgomery a tool  
set; and

WHEREAS, the purchaser intends and requests that the  
City deduct a sum of \$20.00 bi-weekly from the purchaser's  
accumulated wages until such time as the indebtedness, subject  
to no interest, has been satisfied in the amount of \$2,614.90  
dollars; and

WHEREAS, the purchaser understands that the tool set  
and/or tools are not to be removed from the Garage and Shops  
Department until the entire indebtedness has been satisfied;  
and

WHEREAS, the superintendent of the Garage and Shops and/  
or his representative shall from time to time conduct a  
physical inventory of all tools; and

WHEREAS, if it is determined that any items  
such items shall be replaced at the expense of the purchaser;  
and

WHEREAS, in the event the purchaser's employment with the City of Montgomery is terminated either voluntarily or involuntarily before the indebtedness is satisfied, the tool set will be inventoried and any missing tools will be replaced from funds previously paid against the indebtedness by the purchaser and after the Superintendent of the Department of Garage and Shops is reasonably satisfied that all items have been replaced, the purchaser will be reimbursed the balance resulting from the sum total of his payments minus any deductions for the replacement of missing inventory; and

WHEREAS, if it is determined by the superintendent of the Department of Garage and Shops that the purchaser is undergoing a legitimate hardship and is unable to continue payment against his indebtedness for the tools he shall have the option of assigning the balance of the indebtedness with title to the tools to another employee of the Department of Garage and Shops willing to accept the indebtedness or he may assign the tools and the balance of the indebtedness back to the Department of Garage and Shops.

NOW THEREFORE, IN CONSIDERATION of \$2,614.90Dollars, and other valuable consideration in hand paid by the purchaser and the City, the receipt and sufficiency of which is hereby acknowledged, it is understood and agreed by the parties as follows:

1. The purchaser shall be issued a set of tools with an inventory of said tools to be attached as Exhibit "A" and incorporated herein as a part of this agreement.

2. The purchaser hereby agrees to incur an indebtedness for such tools in the amount of \$2,614.90Dollars and hereby authorizes the Department of Finance for the City of Montgomery

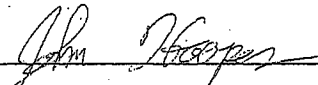
to deduct bi-weekly payments in the amount of (\$20.00) Twenty Dollars from his accumulated wages bi-weekly.

3. It is understood and agreed that until the indebtedness is satisfied the City of Montgomery shall retain complete ownership to all tools and the purchaser is responsible for any inventory loss.

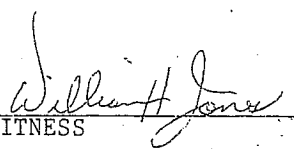
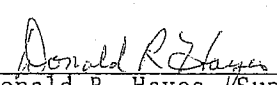
4. It is also understood and agreed that one of the purposes for the City of Montgomery to enter into this agreement is so that the employee will use the tools purchased under the agreement to fulfill his job with the City and that if the employee fails to use the tools accordingly prior to satisfying the indebtedness, this agreement is terminated and full possession of the tools reverts to the City.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed on the date first above written.

WITNESS

  
Employee, Department of Garage  
and Shops

WITNESS

  
  
Donald R. Hayes, Superintendent  
Department of Garage and Shops





STATE OF ALABAMA )

COUNTY OF MONTGOMERY )

AGREEMENT

THIS AGREEMENT made this the 7th day of February, 19 85, John W. Hooper, an employee of the City of Montgomery, Department of Garage and Shops (hereinafter referred to as "purchaser") and the City of Montgomery, Alabama, a municipal corporation (hereinafter referred to as "City") witnesseth:

WHEREAS, the City is desirous that its employees in the Department of Garage and Shops purchase and retain ownership of mechanics' tool sets so that said tools can and will be used by such employees in carrying out their job with the City; and

WHEREAS, the purchaser is a mechanic employed by the City of Montgomery, Department of Garage and Shops and is desirous of purchasing from the City of Montgomery a tool set; and

WHEREAS, the purchaser intends and requests that the City deduct a sum of \$20.00 bi-weekly from the purchaser's accumulated wages until such time as the indebtedness, subject to no interest, has been satisfied in the amount of \$2,773.40 dollars; and

WHEREAS, the purchaser understands that the tool set and/or tools are not to be removed from the Garage and Shops Department until the entire indebtedness has been satisfied; and

WHEREAS, the superintendent of the Garage and Shops and/or his representative shall from time to time conduct a physical inventory of all tools; and

WHEREAS, if it is determined that any items are missing, such items shall be replaced at the expense of the purchaser; and

WHEREAS, in the event the purchaser's employment with the City of Montgomery is terminated either voluntarily or involuntarily before the indebtedness is satisfied, the tool set will be inventoried and any missing tools will be replaced from funds previously paid against the indebtedness by the purchaser and after the Superintendent of the Department of Garage and Shops is reasonably satisfied that all items have been replaced, the purchaser will be reimbursed the balance resulting from the sum total of his payments minus any deductions for the replacement of missing inventory; and

WHEREAS, if it is determined by the superintendent of the Department of Garage and Shops that the purchaser is undergoing a legitimate hardship and is unable to continue payment against his indebtedness for the tools he shall have the option of assigning the balance of the indebtedness with title to the tools to another employee of the Department of Garage and Shops willing to accept the indebtedness or he may assign the tools and the balance of the indebtedness back to the Department of Garage and Shops.

NOW THEREFORE, IN CONSIDERATION of \$2,773.40Dollars, and other valuable consideration in hand paid by the purchaser and the City, the receipt and sufficiency of which is hereby acknowledged, it is understood and agreed by the parties as follows:

1. The purchaser shall be issued a set of tools with an inventory of said tools to be attached as Exhibit "A" and incorporated herein as a part of this agreement.

2. The purchaser hereby agrees to incur an indebtedness for such tools in the amount of \$2,773.40Dollars and hereby authorizes the Department of Finance for the City of Montgomery

to deduct bi-weekly payments in the amount of (\$20.00) Twenty Dollars from his accumulated wages bi-weekly.

3. It is understood and agreed that until the indebtedness is satisfied the City of Montgomery shall retain complete ownership to all tools and the purchaser is responsible for any inventory loss.

4. It is also understood and agreed that one of the purposes for the City of Montgomery to enter into this agreement is so that the employee will use the tools purchased under the agreement to fulfill his job with the City and that if the employee fails to use the tools accordingly prior to satisfying the indebtedness, this agreement is terminated and full possession of the tools reverts to the City.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed on the date first above written.

Cheryl Stephens  
WITNESS

John Hayes  
Employee, Department of Garage  
and Shops

William H. Jones  
WITNESS

Donald R. Hayes  
Donald R. Hayes, Superintendent  
Department of Garage and Shops